

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Embassy Suites Hotel
1250 22nd Street, N.W.
Washington, D.C.

Thursday, November 18, 1999
10:37 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair
JOSEPH P. NEWHOUSE, Ph.D., Vice Chair
BEA BRAUN, M.D.
SPENCER JOHNSON
PETER KEMPER, Ph.D.
JUDITH R. LAVE, Ph.D.
DONALD T. LEWERS, M.D.
HUGH W. LONG, Ph.D.
FLOYD D. LOOP, M.D.
WILLIAM A. MacBAIN
WOODROW A. MYERS, JR., M.D.
JANET G. NEWPORT
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
MARY K. WAKEFIELD, Ph.D.

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1 P R O C E E D I N G S

2 DR. WILENSKY: Our first session is on the home
3 health prospective payment session.

4 DR. KAPLAN: As you know, the proposed rule on
5 home health prospective payment system was issued the end of
6 October. Today, after a brief review of the key elements of
7 the home health PPS, commissioners will be asked to discuss
8 issues related to the proposed rule.

9 Decisions will be incorporated in the draft
10 comment letter which you will receive in the December
11 meeting mailing. You will have the opportunity to finalize
12 comments on the proposed rule at the December commission
13 meeting.

14 Briefly, the key features of the proposed home
15 health PPS, HCFA has proposed implementation of the PPS for
16 all beneficiaries and all home health agencies on October 1,
17 2000. They propose 60-day episodes which will be unlimited
18 for eligible beneficiaries. The episode will include all
19 home health goods and services, including non-routine
20 medical supplies. DME is not included in the payment rate
21 but on the consolidated bill.

22 They proposed four exceptions to the 60-day

1 episode. One, low utilization episodes of one to four
2 visits. Two, transfer to another home health agency within
3 the episode. Three, discharge from the home health agency
4 after a completed plan of care and then readmission within
5 the episode time frame. And the fourth, a significant
6 change in condition sufficient to warrant a new OASIS
7 assessment and a new case-mix group.

8 The home health PPS will be case-mix adjusted.
9 The case-mix demonstration, using the OASIS, included 17,000
10 beneficiaries in a sample from 90 home health agencies in
11 eight states.

12 The proposed case-mix system, which is named the
13 home health research groups, or HHRGs -- a new acronym for
14 us, has 80 case-mix groups which have three dimensions:
15 clinical severity has four levels, functional status has
16 five levels, and service four levels. The case-mix rates
17 range from .5276 to 2.5702.

18 The case-mix is based on 19 OASIS elements plus
19 projected therapy use. Therapy use is confirmed from
20 billing records. It is a minimum of eight hours, which is
21 equal to 10 visits, physical therapy, occupational therapy,
22 and/or speech therapy.

1 HCFA proposed a methodology to pay for episodes
2 with extraordinary costs. The outlier policy, which
3 establishes a fixed dollar loss or a threshold for all case-
4 mix groups. Home health agencies will be paid a case-mix
5 adjusted rate plus 60 percent of costs above the sum of that
6 rate and the threshold.

7 HCFA's proposed use of national averages results
8 in substantial redistribution, both by type of home health
9 agency and by reason.

10 As you can see on this slide, and it's not in your
11 handouts, the free-standing for-profit home health agencies,
12 both in urban and rural areas, will experience decreases.
13 Government home health agencies will have the largest
14 increase. In the proposed rule, HCFA says that Governmental
15 home health agencies account only for 2.6 percent of total
16 home health spending. Also, traditionally, their costs are
17 lower and visit use per episode is much lower than other
18 home health agencies.

19 We've prioritized the order of the issues for
20 commission discussion. I'll be referring to the part of
21 your mailing materials that has the title Commission
22 Discussion of the Proposed Rule. It looks like this. I

1 will give you page numbers for each discussion point.

2 [Indicating.]

3 The first is unit and scope of payment, which is
4 on page two of your handout. HCFA proposes a 60-day episode
5 for all goods and services except DME. As you can see in
6 the default comment, staff analysis supports the 60-day
7 episode. I'd like you to comment on this issue.

8 DR. WILENSKY: Do you want to have the comment
9 issue by issue?

10 DR. KAPLAN: Please.

11 DR. NEWHOUSE: I'm fundamentally out of sympathy
12 with this big a unit of payment. I mean, we've been paying
13 per visit and now we're going to go to 60-day episodes.

14 As Sally said, there is a threshold of four visits
15 and below, but Sally also prepared a distribution of visits.
16 Do you have a slide of that, that you can put up?

17 DR. KAPLAN: Yes, I do. It's figure 1. This is
18 from the one to 20 visits.

19 DR. ROWE: This one is a bump-up at 12?

20 DR. KAPLAN: Yes.

21 DR. NEWHOUSE: So this distribution shows the
22 number of beneficiaries getting each number of visits.

1 But as you can see, it's really very smooth which
2 says that there will be an incentive to get from four to
3 five, to get the full episode payment. That's on the one
4 side.

5 Now HCFA, of course, says that they will institute
6 medical review if there's a spike there, but it's not clear
7 to me that we have such well-defined criteria for review
8 that we can say the fifth visit was or was not necessary in
9 the same sense that we could say an extra day in the
10 hospital was or wasn't necessary.

11 Similarly, at the high end, I'm concerned about
12 incentives to stint. Again, HCFA says they're going to
13 monitor quality and outcomes, but I just don't think our
14 ability to monitor quality and outcomes is really good
15 enough to rely on making this no marginal revenue for
16 another service.

17 And in fact, the Tab B material, to me, makes the
18 case that we don't know, we don't have a very good ability
19 to measure outcomes in this area.

20 To me, the bottom line, given this is really I
21 think a very large change in incentives, is to slow the
22 transition, or go to some kind of transition, so you get

1 some kind of read about what the behavioral responses will
2 be to this change in incentives. But I'd certainly be
3 interested in what other people think about it.

4 DR. WILENSKY: I just wanted to ask, as we're
5 speaking about this -- Joe and I have had some discussion
6 about this among ourselves and through e-mail prior to the
7 meeting. To the extent there is concern about the dramatic
8 nature of the change being proposed, from having gone from
9 one extreme to a service payment basis, which is a very
10 micro unit to now talking about a 60, less aggregated than
11 the 120-day that was initially proposed but still a very
12 aggregated unit.

13 The other area that I would like us to discuss, in
14 addition to the notion of transitioning or slowing down the
15 adoption in order to try to have a better sense of what
16 we're doing is the basic concept of how commissioners feel
17 about something like a 60-day episode.

18 The concern that I had, although I don't know how
19 well informed a concern it is, is that that is such a big
20 unit in what seems to be a pretty amorphous type of service
21 distinction, unlike for example hospital admissions or
22 discharge for very specific DRGs where you have a much more

1 defined activity that is being done.

2 I am uncomfortable in the aggregated grouping, of
3 something like a 60-day episode, as to whether we can define
4 what is reasonably in that episode and whether or not having
5 something substantially smaller, not at the service level or
6 the three or four or five or six day, might not also make
7 sense.

8 Again, some of you have thought about this or
9 worked on this far more than I have, but if we could have
10 that. Because even though transitioning would give us some
11 time to figure out what we're doing, it still ultimately
12 goes to the notion that a 60-day episode fundamentally makes
13 some sense.

14 And so if we could have that discussion.

15 DR. NEWHOUSE: I might add, to me, the physician
16 is much more centrally involved in the decision about
17 whether to extend an extra day in the hospital than whether
18 to have another home health visit or two or three or not.

19 It seems to me one of the consequences of this
20 will be to potentially up the burden on physician
21 certification, which I'm not sure physicians are prepared to
22 cope with.

1 MR. MacBAIN: As I read the information, it seemed
2 to me that talking in terms of the 60-day episode may be a
3 bit misleading, and maybe I'm misreading it. What is it,
4 there are 80 different rate cells; is that correct?

5 DR. KAPLAN: That's correct.

6 MR. MacBAIN: And the actual anticipated number of
7 days in a large number of those rate cells, I would guess,
8 is significantly less than 60 days; is that right?

9 DR. KAPLAN: There's no way to tell that.

10 DR. WILENSKY: And you're still paid for it. Once
11 you cross the four-day line, unless you have an interrupted
12 visit because you go to an acute hospital, you change your
13 diagnosis or your clinical indicator in a significant way,
14 it's based on the notion of a 60-day episode. Your payment
15 is a function of these 80 classes.

16 MR. MacBAIN: But does that mean you're paid for
17 60 days, even if you only use two or three additional.

18 DR. NEWHOUSE: You get paid the mean of the cell.
19 I had Sally do some coefficient of variations on these,
20 which I was going to bring. Most of them, I would say, are
21 on the order of in the .4 to .7 range.

22 To translate that, if this were a normal

1 distribution -- which it isn't, it's skewed right. But if
2 it were normal, 95 percent of the cases would be plus or
3 minus the entire mean. So we're talking about spreads from
4 nothing to twice the mean, in terms of what goes on now,
5 that we're going to pay at the mean within the cell.

6 DR. KEMPER: You take out the outliers, though.

7 DR. NEWHOUSE: Yes, you take out the outliers.
8 You didn't do that in these CVs, right? You didn't take out
9 the outliers.

10 DR. KAPLAN: No.

11 DR. NEWHOUSE: Although the fact that it's not --

12 MR. MacBAIN: That helped. If the variation is
13 similar to what it is for DRGs, for instance, where some of
14 the DRGs assume a relatively short length of stay and some
15 assume a longer one, then we're really not talking about 60
16 days. But if, in fact, at that fifth day --

17 DR. NEWHOUSE: It is similar, but that's why I
18 made my comment about the physician. I have the sense that
19 there's much better sense of what the stay should be than
20 what the length of the home health spell should be.

21 MR. MacBAIN: So the average for even the low
22 payment cells is a substantial number of days. So when you

1 go from four days --

2 DR. NEWHOUSE: There's a spread within every cell.

3 MR. MacBAIN: But the average at which the cell is
4 paid assumes --

5 DR. NEWHOUSE: Assumes the mean.

6 MR. MacBAIN: Which is a fairly high number of
7 days.

8 DR. ROSS: Be careful to distinguish between days
9 and visits.

10 MR. MacBAIN: But the episode is days, right.

11 DR. ROSS: The episode is days, but your notion
12 sounds to me like it's a visit notion.

13 MR. MacBAIN: I'm ultimately trying to get to
14 cost. Does the payment reflect an assumption that the cost
15 for a number of these cells is going to be quite low? Or
16 are all the cells assuming that once you pass that once you
17 pass that four day threshold, the cost is going to be
18 characteristic of 30 or 40 days.

19 DR. KAPLAN: I'll have to get back to you on that.
20 I don't have the answer to that question. Basically, it's a
21 60-day episode.

22 MR. MacBAIN: Maybe it would be helpful if we

1 could get the spread of payment rates.

2 DR. NEWHOUSE: Do you want to see the coefficient
3 variation and the weights? I have it here.

4 MS. RAPHAEL: Could we also see the relationship
5 of visits to days? Is there anything at all that shows
6 that?

7 DR. KAPLAN: I'm not sure that there is anything
8 that shows that. There's nothing among the research or the
9 rule that shows that.

10 DR. LAVE: I have to confess, I haven't read this
11 as thoroughly as I would like to have, but I did look at it.
12 I had a couple of concerns and questions.

13 First of all, it wasn't clear to me why you would
14 use the same number of days as the outlier status for each
15 of these groups. It just sort of strikes me that if I was
16 severe, severe, severe, severe, severe, that that's very
17 different than being whatever it is. So sort of having a
18 four day outlier status for every group, regardless of how
19 it was classified, struck me as being a little strange.

20 If you think about the DRG outlier on the other
21 side, it's a function of the overall cost of care. So that
22 the outlier goes up with the cost of the care.

1 The second thing is it wasn't terribly clear to
2 me, for some of these low-weighted DRGs or whatever we call
3 them, HHRGs, whether or not the expected number of visits
4 would actually be very close to what is the outlier --

5 DR. NEWHOUSE: You meant the left outlier.

6 DR. LAVE: We're talking about the left outlier.
7 That is, that if I have a case-mix rate of .52, and if I
8 remember, something like 10 percent of the people or 20
9 percent of the people have four days or less.

10 DR. NEWHOUSE: Bill's got the means there, so if
11 you said one visit is \$100, you could approximate that.

12 DR. LAVE: But I just remember looking at the
13 distribution of the visits that we saw earlier and what they
14 looked like. There were a significant number of cases who
15 had four or fewer --

16 DR. NEWHOUSE: There it is.

17 DR. LAVE: But that's not quite -- but if you look
18 at this, it turns out a significant number of these cases
19 had five or fewer visits. And what's not clear to me is why
20 those cases -- that that wouldn't define a case-mix group.

21 The definition of the group seems to be a little
22 strange. I don't understand why there aren't a number of

1 HHRGs for which, in fact, the expected number of visits
2 would be four, and that should define the group as opposed
3 to an outlier status.

4 So that leads me to some questions about how the
5 groups, in fact, are defined.

6 The second question that I had had to do with what
7 is being bundled into the cost of care that you are supposed
8 to be paid for under the HHRG case-mix system? Let me say
9 where this is coming from. If I look at the SNF payment,
10 under SNFs, they threw in a lot of cases and service which
11 SNFs were never responsible for. They now said that they
12 should be --

13 DR. WILENSKY: Everything but durable medical
14 equipment.

15 DR. LAVE: I know the DME is out, but what is in,
16 which traditionally home health agencies were not
17 responsible for? Is there anything that is in that home
18 health agencies were not responsible for earlier?

19 DR. KAPLAN: No. It's just that the non-routine
20 medical supplies are included in the episode and --

21 DR. LAVE: Non-routine medical supplies. But
22 under the old system the home health agencies would have

1 been responsible for that, or not responsible for that?

2 DR. KAPLAN: They would have billed that
3 separately.

4 DR. LAVE: And it would have come through the home
5 health agency, not through my going to the local drugstore
6 and picking it up?

7 DR. KAPLAN: Yes, for the most part.

8 DR. LAVE: So that basically, the system is not
9 making the same kind of change, with respect to what the
10 home health agencies are responsible for, as the SNF PPS
11 system did with respect to what the SNFs were responsible
12 for?

13 DR. KAPLAN: No. Basically, under the IPS those
14 non-routine medical suppliers were also in the bundle, if
15 they were under a per beneficiary cap for a limit.

16 DR. LAVE: So they're not throwing services in
17 that were not there before?

18 DR. KAPLAN: No, and it does vary with case-mix,
19 as well. The medical suppliers do vary with case-mix.

20 DR. LAVE: I can understand that. But do you have
21 any sense of these low weighted case-mix systems, what the
22 expected number of visits, in fact, were?

1 DR. KAPLAN: No.

2 DR. KEMPER: I certainly share Joe's concern about
3 the radical nature of the change that's going on, though I
4 think I'm somewhat more sanguine in the sense that this is
5 an area where there's been great concern about the growth of
6 costs. So what's the alternative? I mean, some change is
7 needed.

8 The other thing is that the demonstration --

9 DR. NEWHOUSE: The presumption is then that the
10 growth in costs didn't bring commensurate benefits.

11 DR. KEMPER: I think there has been some debate
12 about that, but certainly some belief that not all of the
13 care was necessary.

14 I guess the other thing is the demonstration
15 results were pretty favorable, although they're not all in
16 and we ought to look at the quality results.

17 Nonetheless, I think there's a real concern about
18 what the quality implications might be. So that leads me to
19 think about a couple of things. One is the phase-in and a
20 phase-in that's over a long period of time and that is
21 relative to costs rather than the IPS. So that we try to
22 get as close in the mixed payment, as close to marginal

1 costs rather than a more complicated system with caps and so
2 on.

3 Secondly, to build in a refinement, not just of a
4 rebasing but a re-look at the system at a defined point down
5 the road, and to think now about what data would be required
6 for that.

7 I guess the other piece, where to me it seems we
8 ought to do some thinking -- I mean, part of thinking about
9 the phase-in is the possibility that you might want to stop
10 the phase-in partway through.

11 DR. NEWHOUSE: To be clear, there is no phase-in.

12 DR. KEMPER: No, but I think it's very important
13 to have one, and as part of that to collect the data that
14 you would need to refine it. But that it's possible that
15 one might stop the phase-in when you got to 50/50, or
16 something like that, to have kind of a mixed incentive for
17 additional visits but also some control. So be able to
18 monitor that and have sort of a mixed episode for per visit
19 payment that had a mixed incentive in it.

20 So I guess the final thing is the real problems of
21 smoothing at the margins of the start-up, this huge initial
22 payment at the end of four days and wanting to think about

1 some inlier smoothing of that, as sort of symmetric with the
2 outlier payments at the end, so that you mitigate this huge
3 incentive at day four or day five, and have some smoothing
4 of that.

5 MS. NEWPORT: I guess my initial intuitive
6 reaction to this was in alignment with other statements, in
7 terms of the magnitude of the change and what possible
8 impact that will have in the transition. It seemed to me
9 that looking at some of the numbers in terms of the impact
10 on various types of institutions, there's a lot of moving
11 parts and a lot of potential there, I think, for problems
12 that would need correction going forward.

13 I was also struck, the 60-day episode piece struck
14 me as well, in the same way it seems to as others. Is too
15 much too much? Or is that too little? Or where do you draw
16 the line? And when you draw a line, for example, at four or
17 five visits and then concentrate your effort on auditing
18 visits five, six, and seven, are you missing something else
19 in the quality measures?

20 I'm skipping around a little bit, but I think that
21 that's something that intrigues me, in terms of looking at
22 past practices, profound changes in the market right now, in

1 terms of effect on these agencies and their response to
2 different regulatory initiatives. And then is that
3 meaningful, going forward and establishing a 60-day period
4 with some cut off under a certain number of visits?

5 I don't know what the bright line is, but it's
6 something we need to look at.

7 Just to get back to your unit and scope of
8 payment, a default comment is there's a statement made here
9 in the second paragraph, this method would reduce financial
10 incentives for agencies to recruit beneficiaries who are
11 already being provided services by another agency.

12 I'm not sure on what grounds that statement is
13 made, and I don't understand what happens in this area, I
14 guess, to understand how agencies may recruit from another
15 agency that's providing services.

16 DR. KAPLAN: I think the issue is really more that
17 if a person changed home health agencies -- you're referring
18 to the exception where it's a beneficiary initiated change
19 to a second home health agency? And they basically plan to
20 pay a pro-rated partial episode payment for the first home
21 health agency and then start a new 60-day episode for the
22 second home health agency.

1 MS. NEWPORT: So it's not recruitment by the
2 health agency, it's recruitment by the beneficiary?

3 DR. KAPLAN: Right. But the concern that staff
4 expressed was that if you started that 60-day episode, it
5 could be as far as 45 days into the first episode that the
6 person decided to change home health agencies, and here
7 you're paying another 60 days.

8 So that is why we basically, as the default
9 comment, were saying that we would like to see it pro-rated
10 on both ends.

11 DR. LONG: I really don't understand this. I have
12 tried. I think part of it is trying to get my head to make
13 the transition from a system I understand a little bit
14 about, which is DRGs, to a system of HHRGs, which are
15 clearly completely different and shouldn't be in the same
16 mindset, even though they have that word group associated
17 with them.

18 And I'm struggling with this notion of a calendar
19 period of time as the basic unit when you're talking about
20 episodic events within that period of time that do not, in
21 any sense, relate to what we all think about in terms of an
22 inpatient situation, which is a continuous situation.

1 I think we have the potential here of creating
2 some sort of an extraordinary, either regulatory oversight
3 burden or burden on the physician who is constructing the
4 care plan. And I don't know what these care plans look
5 like, but I can see them evolving perhaps to specifying
6 exactly the frequency and number of visits and the services
7 within each one, which I think they don't do now.

8 I mean, I look at this chart that we have up here
9 on the screen, and in theory at least 100 percent of the
10 data on that chart could be low utilization episodes,
11 because that's per year. And we're in a 60-day mode here.
12 And if I do four in 60 days and I have a consecutive set of
13 60-day episodes, everything that's on that chart could be
14 low frequency, low utilization.

15 That chart doesn't help me at all. It doesn't
16 help me at all in understanding why we're picking four and
17 not five or six. I just don't see how this thing hangs
18 together and the potential for gaming is enormous. Now that
19 we're in day 57 and we're one visit short, let's do another
20 visit. Are we going to audit just the visits that happened
21 in the last five days of the 60-day episode? Or are we
22 going to look at the fifth visit that occurs on the fifth

1 day?

2 I mean, I'm just not understanding how this
3 supposed to hang together.

4 DR. KAPLAN: HCFA's rationale for choosing the
5 four, I think this chart better explains their rationale.
6 It's because in 1994 you have 80,000 beneficiaries who
7 receive four or five or six visits. And in 1997 you've got
8 95,000 beneficiaries who received four, five or six visits.

9 DR. LONG: But that's over 12 months. That's not
10 over 60 days.

11 DR. KAPLAN: Yes, that's true.

12 DR. LAVE: I guess the concern I have with that
13 number has to do with these .5 weighted CMGs. We know, from
14 the data that we had before in home health visits, that a
15 significant number of individuals, in fact, had a very small
16 number of visits.

17 And so, somehow or other, I would imagine that
18 those individuals somehow or other ought to be classified
19 into these very low-weighted HHRGs. And so it's not clear
20 why they are an outlier, as opposed to being a low-weighted
21 HHRG for people who come home from the hospital, they need
22 two or three visits. That those should be the low-weighted

1 HHRGs.

2 I mean, that's what I'm finding this tremendous
3 problem with, is sort of the concept of the outlier. And
4 then we know that a substantial number of people have these
5 very low number of visits. And so what are the low-weighted
6 DRGs if they're not the people who have four visits? I
7 mean, that's one of the problems that I have with it.

8 DR. KEMPER: Can you get us this graph for some of
9 the rate cells so that we can see for a high payment cell
10 what it looks, so we can relate it to some conditions of
11 patients.

12 DR. KAPLAN: I'm not sure. I can try.

13 DR. KEMPER: Because the aggregate doesn't tell
14 you that.

15 DR. NEWHOUSE: But it does tell you that those
16 97,000, or whatever, are going to fall into some cell.

17 DR. LEWERS: You don't that need that chart to say
18 that.

19 DR. ROWE: I pass. I want to hear what Carol has
20 to say. She knows more home care than anybody I know.

21 MS. RAPHAEL: I'm going to take a very contrarian
22 view here. I think stepping back and looking at this whole

1 system and what we're trying to do, and what's the unit of
2 production? What is it that we're trying to move toward?

3 Right now the unit of production in home health
4 care are visits and hours. That's what we produce.

5 The way I look at this is this is transformational
6 because what we're trying to produce in the new system are
7 some outcomes associated with one of these resource groups
8 and tied to OASIS, this whole system of assessing and
9 measuring outcomes.

10 So what I'm telling my staff of 7,000 is what
11 you're responsible for now is producing certain outcomes
12 that I'm going to measure. If someone has a stroke and they
13 get rehabilitation, I want to know where they are at the
14 admission point and where they are at the discharge point,
15 and I want to see improvement. And that's what I'm going to
16 be looking for, and that's what we're being paid for.

17 What you do to achieve that improvement can vary.
18 It doesn't have to be a visit. Maybe it's going to be a
19 telephone call. Maybe it's going to be a three hour visit
20 on the first say and two shorter visits later on.

21 I kind of thing that this will give us a different
22 way of looking at patient care and thinking about what this

1 is all about. So for me this is important because I'm
2 trying to move away from incentives which are very tied to
3 how many visits and how many hours. On the other hand, I
4 appreciate the discomfort level of this amorphous block of
5 time and exactly what are we paying for in this amorphous
6 block of time.

7 Also, I am now and many other organizations like
8 mine, have been living under an interim -- and I underline
9 interim -- an interim payment system which was a very blunt
10 instrument of public policy for very understandable reasons,
11 given this enormous growth rate with no clear understanding
12 that benefit came out of this enormous growth rate and
13 utilization and expenditures.

14 But it is a blunt instrument and it has no case-
15 mix adjuster. So if you are an organization that is dealing
16 with high acuity, severely ill patients, there is no way
17 today that the system, in any way, acknowledges that. And
18 in fact, I might argue that if you have worked hard to be
19 efficient and to keep your costs low, in fact, you're
20 punished to some extent under the current system.

21 So what am I looking for? I'm looking for some
22 movement to a system that will, in fact, reward and

1 encourage efficiency and will in some way discriminate among
2 those people who enter based on what their real acuity and
3 need level is.

4 I want to move toward that system as expeditiously
5 as possible.

6 DR. MYERS: Is this that system?

7 MS. RAPHAEL: I'm not going to take any system
8 just to get out from under the current of circumstances. So
9 I'm not sure that this, as is it is currently set up, is
10 that system. But I do see certain parts of it that I think
11 make sense, because right now the 60 days does match two
12 things. It matches current practice, which is you admit
13 someone and right now it's 62 days later that you recertify
14 someone and go back to the physician and work out another
15 plan of care. So it is tied into the way people currently
16 manage and practice.

17 Secondly, it's tied into the OASIS system, which
18 is quite an elaborate system and it has certain problems,
19 but it is the best that we have seen thus far in terms of
20 measuring functional outcomes and tying into diagnoses. And
21 that's supposed to be done every 60 days. So that if you
22 have someone stay for 60 days, you go back and do this kind

1 of reassessment of ability and outcomes.

2 So I can see from a point of view of trying to
3 keep it simple, this does make sense. And I also believe
4 that, from my point of view, there's a large proportion of
5 patients who are only in care for 60 days or less. There's
6 an even larger proportion that are in care for 30 days or
7 less, and that's something to look at. And I would like to
8 look at that in greater detail.

9 But from when I last looked at our data, the
10 largest proportion of patients are the 30 day or less group.
11 And then you have another very substantial consumer of
12 resource group that's at the tail end, that really stays
13 probably for two or more episodes.

14 And what I don't yet understand is how this system
15 deals with those two key groups, which are very disparate in
16 their needs.

17 I think there were other issues that were raised
18 that I'd just like to comment on. One is the issue of the
19 need for monitoring, and I guess you Hugh said this, and
20 others. In my experience, very often dollars don't go into
21 the part that has to do with monitoring and administering
22 the system. Very often there's inadequate appropriation,

1 because you want to put it into care and service, not into
2 the administration end of it.

3 I do have worries about the kind of monitoring
4 that would be needed to really sustain a system of this
5 sort, and the level of medical review. Under the
6 demonstration, there was 100 percent medical review at the
7 outset and then the fiscal intermediaries could not sustain
8 that level of medical review and I believe that it was
9 dropped to 25 percent medical review.

10 But even 25 percent medical review, one out of
11 four, is quite a high level of medical review to sustain in
12 a system of this sort. So I just think that we need to pay
13 more attention to what this really would require on the part
14 of the fiscal intermediaries and HCFA to monitor and make
15 sure there are not poor incentives driving behavior here.

16 And then I think there is an issue around the
17 small agencies. In some ways, home health care is an
18 unusual industry and many of the agencies are quite small.
19 I think they might have a very hard time with this kind of
20 system for a variety of reasons. It's fairly sophisticated,
21 it takes a lot of new systems, and there are issues around
22 cash flow. And I really don't know whether or not they can

1 survive in this environment, and it may affect rural
2 agencies as well.

3 And then I guess I would also speak a little bit
4 about the role of the physician because right now the
5 physician is required, at least as we understand it, to
6 certify which of these 80 HHRGs a patient falls into. I
7 think that's going to be near to impossible for a physician
8 discharging someone in the hospital or seeing them in the
9 community to even understand these 80 categories and really
10 assign someone to those categories.

11 So I think we really need to take a look at that,
12 because I don't think it's at all realistic.

13 DR. WILENSKY: My sense of the Commission, and
14 this we will obviously see reflected when we come back to
15 see in December, our version of how we want to approach
16 these comments, is not whether or not there are real
17 problems with the existing system of payment, including some
18 perverse incentives or lack of incentives to focus on
19 producing better care.

20 But the specifics now, now that the argument has
21 sort of already gone beyond changing the payment, the
22 specifics become very important.

1 So my sense would be at least, to the extent that
2 you or people who come out of the field as you do may have
3 some questions about specifically 60-day, 40-day, 30-day,
4 where monitoring or the requirement of physicians to specify
5 which of the 80 HHRGs the patient belongs into. I mean,
6 this is now at a level where this kind of specificity is
7 very important. So I can certainly sympathize with the
8 frustration with regard to the current system.

9 At some point, as we found with regard to risk
10 adjustment and the strategies, that we may find ourselves in
11 the position of saying the data isn't what we need but
12 what's been proposed is the best that can be done with the
13 existing data.

14 Some of the issues that are getting raised here
15 may or may not fall into that classification, which is the
16 only way we could do it because of existing data, as opposed
17 to this is the way HCFA has chosen to recommend that we go
18 forward. And to the extent that we think there are issues
19 that may not have been taken into consideration or other
20 ways that might seem to us to be better or at least equal in
21 terms of consideration. And that really is, I think, what
22 we need to try to get on the table before we get our comment

1 letter back in.

2 DR. LEWERS: I'd just second what Carol has said
3 about physicians and I want to just refer the commissioners,
4 if you need to look this up to get just a hint of this, take
5 a look at the October 28th Federal Register because I looked
6 up physicians in there.

7 If you go to the next to the last page, I'll just
8 read it it's simple. It says a condition of payment for
9 home health under Medicare Part A and Medicare Part B, a
10 physician must certify as follows. And then it says the
11 individual is correctly assigned to one of the home health
12 resource groups. That's on page 58,207. Now pay close
13 attention, because I'm moving. It's 525.22(a) and then
14 suddenly jumps to (b). I don't understand that either,
15 right in the middle of the page.

16 So it doesn't say who determines what HHRG they're
17 in but it says the physician has to certify it.

18 Now, just to convince you, go to page 58,173 and
19 174. Physicians are very concerned about counting and
20 adding numbers. I mean, we've just gone through that with
21 the E&M documentation. And here we're doing the same thing
22 all over again with scoring systems.

1 Just take a minute, either now or later, and read
2 the stuff on 58,174 and tell me that your average physician
3 is going to read all this, understand it, and be able to
4 handle it and be able to do that for 80 groups. It's not
5 going to work.

6 DR. ROWE: We obviously need more GME.

7 [Laughter.]

8 DR. LEWERS: But the point that I'm making is,
9 this is an access problem. And with fraud and abuse, we're
10 already having problems getting physicians to certify some
11 of the issues right now. And if you think this is going to
12 work, I think this is a major element we need to focus on,
13 because this is just not going to work.

14 And if you need to, just read that paragraph.
15 I've read it several times and it just doesn't make sense.
16 There's no way you can keep that in mind and then keep doing
17 everything else you've got to do.

18 DR. LOOP: Ted made my point about physician
19 certification, but there's a couple of other questions that
20 I need to ask the home health experts.

21 If there's a 50/50 payment split and the majority
22 of resources are expended in let's say the first 10 days,

1 should this not be 60/40 or 70/30? Or does that encourage
2 perverse behavior.

3 MS. RAPHAEL: I was just trying to get at that
4 when I mentioned smaller agencies because I think they're
5 going to have big cash flow problems because of the fact
6 that this is a 50/50 split and they're probably not going to
7 get the first 50 percent right off the bat. And I'm not
8 going to go through all that you have to do to get that
9 first 50 percent, but it's quite arduous. So I think there
10 may be issues around that.

11 DR. LOOP: The other question, Carol, is does this
12 new punishment, will that affect pushing some patients back
13 into the acute care system? Or do you see that being a
14 perverse behavior here? Will these new rules affect the
15 behavior in that way or am I reading too much into it?

16 MS. RAPHAEL: I don't think it should because if
17 you have a good case-mix adjuster, you should not be
18 reluctant to admit patients under this --

19 DR. WILENSKY: Actually, it should help that.

20 MS. RAPHAEL: Yes, it should.

21 DR. ROWE: It would be an improvement because
22 currently, if you're taking care of a lot of cancer patients

1 with high tech stuff, your payments don't really recognize
2 that, so you'd be reluctant to take those patients.

3 DR. NEWHOUSE: No, wait a minute, you're shoving
4 more of it into the fixed payment for home health, though,
5 if they were going to get home health anyway, in this
6 system.

7 DR. ROWE: That's his question, is whether they
8 can stay in the hospital.

9 DR. NEWHOUSE: I understand but I'm not sure we've
10 got the right answer to the question.

11 DR. LOOP: It's the same question.

12 DR. NEWHOUSE: Let's say they get -- here's a mean
13 of \$392 for this case-mix, setting aside the outlier stuff.
14 They're going to get \$392 no matter how long they stay in
15 the hospital, assuming they got into the home health
16 episode. Whereas, under the current system, you get -- it's
17 titrated to the number of visits that you get when you're in
18 the episode. So you've got two conflicting fixed payments.
19 Each group is trying to shift it from one to the other.

20 DR. LOOP: Right, so tell me the answer? Is it
21 better or worse?

22 DR. ROWE: There's Carol's answer and then there's

1 Joe's answer.

2 DR. NEWHOUSE: No, it's not clear who wins with
3 the financial incentive for the hospital to shift out to the
4 home health agency. The home health agency can shift back
5 to the hospital.

6 DR. LOOP: I was really questioning the latter.
7 Is there a perverse incentive for the home health to shift
8 back into the acute care?

9 DR. WILENSKY: It depends how well defined these
10 episodes are.

11 DR. NEWHOUSE: No, still --

12 DR. WILENSKY: There's no payment at the margin
13 and so the one problem you get into is any time you have a
14 fixed payment that doesn't increase the more you do, and by
15 definition when you have a bundled payment that's where you
16 are, if you can get the bundle and get rid of the costs
17 you're always better off.

18 DR. NEWHOUSE: And both the hospital and the home
19 health agency have this incentive now.

20 DR. WILENSKY: To go back and forth.

21 DR. NEWHOUSE: They're fighting with each other.

22 DR. WILENSKY: No, they'll basically bounce back

1 and forth. Stay outside the 30-day window.

2 DR. LOOP: Seems like the bounce is easier back
3 into the system, into the acute, than it is out. Maybe I
4 just don't understand it.

5 DR. WILENSKY: As long as you don't get caught in
6 the 30-day readmission rule, both parties would be better
7 off financially, as long as you're not within the four or
8 five-day inlier policy, which you clearly are not going to
9 be, that you get a certain point -- although if you go back
10 in the hospital there is an adjustment made for the partial
11 episode.

12 DR. NEWHOUSE: But you're right, relative to the
13 current system, the home health agency has more reason to
14 push back.

15 DR. LOOP: Right

16 MS. RAPHAEL: If you come back to the home health
17 agency without a significant change in condition, then you
18 stay within the episode. If you have a significant change
19 in condition, you start a new episode payment. So I think
20 it really depends...

21 DR. ROWE: There's another consideration here.
22 This might be worth a page of thoughtful narrative because

1 there is implicit in this discussion about is it in the
2 hospitals interest or the home care interest that they're
3 run or owned by different organizations. There are a number
4 of organizations, my own included, that own very large home
5 care programs as well as large hospitals.

6 And so you have the same owner on both sides. And
7 you certainly would want, in the best interests of the
8 beneficiary, which I think we should remind ourselves why
9 we're here, to make sure there was not some incentive in a
10 co-ownership situation of bouncing the patient back and
11 forth inappropriately.

12 DR. LOOP: You're right, it's the patient who has
13 the change in condition, and I don't know how you identify
14 that.

15 DR. NEWHOUSE: They go to a different HHRG, as I
16 understand it.

17 MS. RAPHAEL: Right. They're reassessed.

18 MR. MacBAIN: Let me just go back to the
19 statistics of this, which I deal with with some trepidation
20 because I'm not much of a statistician. But from the
21 figures that Joe passed around --

22 DR. NEWHOUSE: They're Sally's.

1 MR. MacBAIN: The standard deviation is anywhere
2 from a half of the mean to the mean? So that the
3 distribution is huge, which to me suggests that this
4 particular system is a lousy predictor of costs, at least
5 given the way the home health services are currently being
6 delivered.

7 DR. NEWHOUSE: At the individual level.

8 MR. MacBAIN: At the individual level. Which may
9 not matter for a huge agency, but could make a real
10 difference for a small agency. I think the figures we saw
11 were 1,000 agencies get \$100,000 or less from Medicare a
12 year. Some of those may experience windfalls. More likely
13 a number of them will get hurt badly by this, particularly
14 when this is added onto a 15 percent cut which is added on
15 to what's already happening to the interim payment system.

16 So I'm very concerned about the impact of a system
17 that itself, because of the wide dispersal around the mean,
18 doesn't look like a good predictor of cost, the impact of
19 this on the small agencies where the number of patients
20 isn't going to be large enough to even out some of that
21 problem.

22 The second point is to go back, because we haven't

1 talked a lot about quality. But Carol was describing a
2 system that encourages or at least doesn't penalize
3 efficiency. But systems that reward efficiency also reward
4 stinting and that, I think, is a real concern, again
5 especially given the broad dispersal around them in each of
6 these rate cells, such that -- if you want to win in this
7 kind of a system, you want to reduce the variance in your
8 own organization, the place you're going to focus on is the
9 high cost patients.

10 Bringing their costs down may be the result of
11 improved efficiency and Carol described what we'd want to
12 happen in all agencies. But there are other ways to do it.

13 DR. NEWHOUSE: And getting more patients in below
14 the mean.

15 MR. MacBAIN: You can bring the high ones down
16 below the mean simply by giving them less care. And because
17 we're talking about people in their homes, they're not
18 visible, they're dependent, they're in the worst condition
19 to try to fend for themselves. I think there are some
20 serious risks in what could happen at the high end of the
21 dispersal in each of these cells.

22 DR. KEMPER: Can you get us numbers with the

1 outliers because I think this high dispersion, and you're
2 saying it's not consistent because of that. It's partly
3 mitigated by the outlier policy.

4 So if you could get us these variances?

5 DR. KAPLAN: I'll see if I can, but those are --

6 DR. LAVE: I'm not sure these coefficients of
7 variation are actually that high. I mean, I think if I
8 remember the DRG data when they first came up, I think we
9 were looking at coefficients of variation at about this --

10 DR. NEWHOUSE: It's comparable, but I'm not sure
11 the problem is comparable. I'm not sure you should use the
12 same standard.

13 DR. LAVE: No, I agree with you, the problem is
14 very different, but I don't think that if I look at these
15 coefficients of variation per se, that they are that much
16 higher than the coefficients of variation, particularly for
17 the medical DRGs that we saw before.

18 So that is a concern. I'm much more concerned
19 about the fact that it's a very different problem and that
20 there's much more flexibility, in fact, in what can or
21 cannot be done and what services can and cannot be brought
22 into the patients.

1 So I think that the monitoring of what goes on in
2 this situation is extraordinarily critical because you're
3 really moving into something quite different from how do I
4 take care of an --

5 DR. WILENSKY: And how defined this unit is that
6 you're paying for which again, in the DRG world, is
7 substantially more defined than it is in the home care
8 world.

9 DR. WAKEFIELD: Mine's really fast. First of all,
10 I just want to underscore what a number of people have
11 already said, and that is a potential impact of facets of
12 this proposed payment on small home health agencies. In
13 particular, my question about the 50/50 split payment and
14 it's potential impact on cash flow.

15 I could guess where that 50/50 split, that chosen
16 split might have come from, but is there any underlying
17 rationale for why 50 on the front end and 50 on the back
18 end, versus any other kind of payment methodology that
19 you're aware of?

20 DR. KAPLAN: There's no statement of it.
21 Basically it does give them half the payment in advance,
22 which basically about 88 percent of agencies receive their

1 payment after they've submitted the bill. Which means
2 they've provided the service, then they submit the bill,
3 then they get payment for 88 percent of the agencies.

4 This will give half of the money, in essence, up
5 front. Not exactly up front, but shortly after they start
6 service. And then the other half, assuming that there's no
7 adjustment, at the end of the 60 days, after the claim has
8 been processed.

9 DR. WAKEFIELD: Because it was 13 percent that
10 were being paid under --

11 DR. KAPLAN: It may be 87 percent. 12 or 13
12 percent are paid on periodic and interim payment or PIP, and
13 that was eliminated by the BBA.

14 DR. WAKEFIELD: Thanks. I was just wondering what
15 the underlying rationale was for that 50/50 split, and to
16 say that hopefully whatever documents are produced, that we
17 speak to concerns about impact on small home health
18 agencies.

19 MS. ROSENBLATT: I have a question for Carol and
20 maybe for Sally. If I read this correctly, it said that
21 HCFA was going totally to the PPS system because of
22 administrative problems with blending two methods. Yet the

1 recommendation in here was to blend two methods.

2 What I'm picking up anecdotally, from the people
3 at our company that are contracting with home health
4 agencies, is that they're saying there should be a
5 transition adjustment because there's just -- like the chart
6 that's in here, there's just too much swing in payment.

7 So I guess I would like to get a feel about what
8 does that really mean? Is it doable?

9 DR. WILENSKY: I think that the discussion, at
10 least that Joe and Murray and I have had, is that it's more
11 a desirability to have the winners win sooner than an
12 administrative feasibility issue. You may have heard
13 differently.

14 It's not my impression that this is not something
15 that is administratively infeasible.

16 DR. KAPLAN: Some of the agencies -- I don't know
17 if disadvantaged is the way you would say it, but they've
18 been disadvantaged under the IPS and this basically shifts
19 it more to the average.

20 DR. WILENSKY: Let me propose how we should
21 proceed. We've taken about an hour for the first line.
22 However, not surprisingly -- which is why I sometimes

1 hesitate about doing first lines -- we have covered about
2 three-quarters of the issues on the list.

3 There are at least two issues that we need to take
4 up to provide some guidance to the staff, in terms of coming
5 back to us. One is the transition issue, although we
6 actually have, in fact, talked about that.

7 It sounds, as I have heard it, is that not
8 surprisingly this commission is interested in recommending a
9 transition. I just wanted to be clear about that. And
10 also, something about the implementation.

11 I would propose, with regard to discussion about
12 the 15 percent reduction, that we hold off until we see what
13 the Congress comes out with in the next couple of days,
14 because it essentially will or won't be moved, so we can
15 delay that discussion.

16 And then if there are other specific issues that
17 people would want to make further comment on, case-mix,
18 monitoring, access, et cetera.

19 DR. MYERS: Was the simplification of the
20 physician assignment issue on the list?

21 DR. WILENSKY: Again, I think that what I expect
22 to come back with is MedPAC is concerned about the

1 requirements on the physicians. I have heard that raised by
2 at least three or four people, and I have not heard anything
3 to the contrary. So I would regard that we have spoken.

4 DR. NEWHOUSE: I have some other issues if you're
5 opening it up.

6 DR. WILENSKY: Yes, I'm about to. But again,
7 that's how I heard that. So I would regard that, that we
8 have given input to Sally.

9 DR. KEMPER: But are we prepared to recommend
10 against a requirement requiring physician authorization?

11 DR. NEWHOUSE: What's the alternative?

12 MS. RAPHAEL: The physician right now has to
13 authorize a plan of care. That shouldn't change. It's how
14 you translate that plan of care into one of these 80
15 categories that we're saying is the responsibility of, I
16 think, the agency.

17 DR. WILENSKY: Let me specifically ask if there's
18 anything further with regard to the transition, and anything
19 further to implementation, but also to any other issues?

20 DR. NEWHOUSE: There's a discussion somewhere in
21 here of coding issues and creep.

22 DR. KAPLAN: That's on page 5 under case-mix

1 adjustment.

2 DR. NEWHOUSE: My concern there was that there was
3 -- I didn't understand how anybody was going to tell the
4 difference between true change and the case-mix index, which
5 there could be a lot of, given the behavioral change here,
6 and coding change.

7 The discussion, as I read it, at least in my notes
8 as I read it, was that the default comment seemed to presume
9 that it was all creep or all coding. I simply didn't know
10 how we were going to differentiate true change from creep.

11 There's substantial changes in payment according
12 to which of these 80 groups that you're in. Just eyeballing
13 that it goes from the high \$200s to over \$1,000, and that
14 could turn on, as I understand it, whether you have one more
15 ADL or one less ADL.

16 So who audits this? If you come back three months
17 later to audit it, how are you going to know what the ADL
18 limitations were back when it was coded?

19 I mean, I have substantial concerns about what
20 we're going to do about case-mix index change here. I don't
21 have any answers to that, but at a minimum I don't think our
22 discussion should presume that the case-mix index change is

1 all coding.

2 The second issue was that, as you said, several of
3 these weights are based on cells with fewer than 50
4 patients, which is -- I mean, you could have picked a
5 substantially bigger number and I still would have been
6 concerned. And that, to me, is just another argument for
7 slowing down the implementation of this, the fact that the
8 weights could be seriously off, even if you bought
9 everything else here.

10 The next thing is you said the transfer rule gets
11 invoked if the patient goes from one agency to another.
12 What happens if the patient goes from the hospital to the
13 rehab unit to home health? Is the transfer rule invoked on
14 the rehab unit?

15 DR. KAPLAN: I'm not sure. I'll have to get back
16 to you on that.

17 DR. NEWHOUSE: And the final thing, you've given
18 us, which probably is all you can give us or all HCFA can
19 give us, the percentage of explained variance by this index.
20 But I don't have a clue about whether that's good or bad. I
21 simply don't know how much variation a very good adjuster
22 ought to explain here.

1 And comparing it with the amount of variance the
2 DRG system explains or anything else doesn't really help.
3 So I don't know what to do about that, but I don't have -- I
4 simply don't know how to judge the case-mix index.

5 DR. KEMPER: I just wanted to see whether the
6 phase-in, whether there's a feasibility issue with doing the
7 phase-in relative to cost based reimbursement rather than
8 the interim payment system?

9 DR. WILENSKY: My understanding is that there is
10 not.

11 DR. KAPLAN: Yes. The way the law reads, I think
12 that that's precluded.

13 DR. KEMPER: What is precluded?

14 DR. KAPLAN: That you have to use the IPS as the
15 blend. If you're going to blend, you need to use the IPS as
16 the blend.

17 DR. KEMPER: Because it seems to me it would be
18 much more desirable to do the phase-in relative to cost,
19 because you'll get much better information and the
20 incentives would be better.

21 DR. ROSS: There's another issue that relates to
22 all of that and that's the amount of confusion you could

1 create by bringing in a PPS blended with cost based
2 reimbursement relative to a change from an IPS that nobody
3 yet understands.

4 DR. KEMPER: People do understand cost-based
5 reimbursement.

6 DR. NEWHOUSE: All the people I talk to understand
7 the IPS and they don't like it.

8 DR. WILENSKY: That's different.

9 DR. NEWHOUSE: They understand it.

10 DR. ROSS: But you're now potentially talking
11 about a blend of two payment systems, neither of which is in
12 existence.

13 DR. KEMPER: Anyway, I think that merits some more
14 thought and discussion.

15 The other question that I would like to raise, and
16 I don't have the answer to this, but what about beneficiary
17 purchased home health? For example, the home health agency
18 says you're ready for discharge and you're no longer going
19 to get services under Medicare, and the individual or family
20 says well, I feel I need services. I'll buy them myself and
21 continue. Are they able to do that?

22 Well, presumably, yes they're able to do that.

1 What happens in the less attractive case where the
2 agency may say you're out of services when, in fact, they
3 need additional services and it has sort of a character of
4 balance billing, in a sense? And is there a way to monitor
5 that at least to say whether that might be happening, at
6 least to see whether that might be happening in some
7 circumstances. I don't know what to do about that issue.

8 DR. NEWHOUSE: It's a stinting issue.

9 DR. KEMPER: It's a stinting issue. The question
10 is whether there's a monitoring that might be useful.

11 DR. BRAUN: I just wanted to bring up in terms of
12 implementation that we consider the education of
13 beneficiaries. I think they've devoted a good bit of time
14 to the education of the agencies, which is absolutely true.
15 But I think with the experience with the IPS, it's going to
16 be really necessary that beneficiaries have the proper
17 education.

18 DR. WILENSKY: Any other comments that people
19 would like to make with regard to instructions to Sally?

20 DR. NEWHOUSE: I guess I have a general concern
21 that I expressed earlier, and this really segues to Beth's
22 discussion next. Nothing in Beth's discussion gives me a

1 warm feeling about the proposed comments here about our
2 ability to monitor quality and outcomes effectively. But
3 maybe that should get saved for the next section.

4 DR. LAVE: I'm not sure where we came down with
5 respect to a transition system. Maybe if we're going to put
6 it in the letter we ought to be somewhat clearer about where
7 we think we would be.

8 If I had a vote, I would like to use a transition
9 system, using not the interim payment but basically a cost
10 based system, because I think it would give you better
11 information. And you sort of have a better idea about what,
12 in fact, it is that you are doing in that type of a system,
13 which is that some marginal payments, at least, is based on
14 some use of services.

15 So I would like to know whether or not, as a
16 commission, and we want to talk about transition, what we
17 want to have the components of the transition consist of?

18 DR. WILENSKY: We get one more round before it
19 goes back. We can try to raise that issue. I believe it
20 would require a different level of complication
21 legislatively and maybe budgetarily than what exists now.

22 So what I'd like Sally to do for us for a December

1 consideration is to address whether or not there are either
2 administrative or legislative issues that would be raised by
3 a transition that used costs as the base to transition from
4 as opposed to the interim payment system. Since normally
5 the transitions occur from wherever you are at that point to
6 wherever you are going.

7 And then we can think about having a tiered
8 recommendation which might say, in the abstract or in
9 general, our preference would be to transition from one
10 base. I think we ought to consider whether we would say in
11 the event that's not possible or legislation required would
12 not be passed in a timely basis, would we prefer a
13 transition from an IPS as the base to no transition at all.
14 Because I think that is a realistic position that we face.

15 Right now, as it's proposed, what we're talking
16 about is no transition from an IPS. I personally would
17 rather have a transition from an IPS than no transition.
18 You may or may not agree with that, in your own view. We
19 can also talk about this other as a possibility.

20 DR. NEWHOUSE: I rather like Peter's suggestion,
21 although I don't know that it's feasible statutorily for
22 HCFA to have a stop or a pause button in the middle of this

1 transition where you explicitly tried to review where you
2 were, particularly given the lag in data acquisition. I
3 mean, I could imagine that even if we were going, say 25
4 percentage points a year toward a full-blown system, that
5 two years in we don't have much of a clue except from
6 anecdotes about how it's working.

7 Until there's some data on how it's working, I
8 would certainly be uncomfortable about going to this system
9 100 percent.

10 DR. WILENSKY: Again, we don't need to make that
11 call now.

12 DR. NEWHOUSE: We may want to make it to the
13 Congress if HCFA needs statutory authority for it.

14 DR. WILENSKY: Whatever we say now...

15 DR. NEWHOUSE: If we were going to make a
16 transition, we could make a general statement that we think
17 there needs to be some transition. We could specify some
18 details about how fast we think the transition ought to go.

19 If we were to go that latter route, then I think
20 it would be reasonable to say and we don't think you should
21 go past a certain point in this transition without having
22 some data.

1 DR. WILENSKY: What I'm saying now is we don't
2 need to make it in November. We're going to come back to
3 this in December.

4 DR. KEMPER: Can we just, next time, have more
5 discussion of the inlier issue, and some more analytic work
6 and maybe some data work that looks at this four days? It's
7 not whether it's four days or six days, but whether there's
8 some options for smoothing that a little bit, so that it's a
9 mixture as you get into the episode.

10 Because that huge cliff is just --

11 DR. NEWHOUSE: Inviting.

12 DR. KEMPER: Inviting. Thank you.

13 DR. WILENSKY: Any further comments on this?

14 You have a lot of work to do, Sally, in the next
15 three weeks.

16 Beth, you had a good introduction by the
17 commissioners.

18 MS. DOCTEUR: First let me apologize if my voice
19 gives out or is annoying to listen to during this
20 presentation. I'm just getting over a cold and it's kind of
21 an annoying twang to my voice.

22 This session relates to the March, 1999

1 recommendation that the commission made, that the Secretary
2 should establish quality monitoring systems for post-acute
3 care as prospective payment systems are implemented. As you
4 know, this recommendation reflected your concerns that
5 changes in payment methods and amounts could have adverse
6 effects for beneficiaries' care.

7 It also reflected some concerns about the
8 program's ability to uncover any changes in the quality of
9 care that occurred given the limited amount of information
10 that's routinely generated for use by the policymakers and
11 program administrators.

12 The purpose of this session really is to give
13 commissioners an opportunity to revisit that recommendation
14 and to say some more about what it is that you had in mind
15 in terms of quality monitoring systems for post-acute care,
16 to begin to think about what the Congress or HCFA ought to
17 do to make these things happen, and what it will be
18 necessary to do to get there from here.

19 The paper that I prepared for this session made an
20 implicit assumption that I think it would be useful to make
21 explicit here. That is that by quality monitoring system,
22 you meant a process that's ongoing, that's data driven, that

1 involves measurement and reporting activities that are
2 designed to yield information on the quality of care.

3 I just wanted to make that clear, that that's sort
4 of a fundamental premise in the paper. So that's up for
5 discussion if that isn't what you wanted it to mean.

6 You've stated that implementation of the post-
7 acute care prospective payment systems is the motive for
8 implementing quality monitoring systems. But I think that
9 it is important to clarify what it is that you want quality
10 monitoring systems to actually achieve. A quality
11 monitoring system obviously could have more than one goal,
12 or could be designed to achieve more than one objective.

13 But I think it would be important to articulate
14 what the priorities are. Because, as the paper tries to
15 make the case, the design of a system really depends on what
16 it is you're trying to accomplish. There are six different
17 potential goals discussed in the paper.

18 The paper describes ways in which quality
19 monitoring systems would be designed differently, depending
20 on what goals you're trying to accomplish. There are at
21 least five characteristics of monitoring systems that would
22 probably vary, depending on the different goals that you

1 were trying to achieve.

2 First is the aspects or the dimensions of quality
3 that you would want to measure. Examples including clinical
4 or technical quality, service quality, and acceptability of
5 the care to the patient or satisfaction.

6 A second characteristic is the types of measure
7 used, including structural measures, process measures,
8 outcomes measures. The third is the type of data used in
9 measurement. There are numerous types of data available for
10 measuring post-acute care quality and we'll talk about that
11 in a little more detail in a moment.

12 Next is the unit of analysis. This is really
13 important because it drives the types of questions that your
14 system can answer. For example, you might be interested in
15 a system that can tell you about the quality of SNF care
16 overall. You might be interested in a system that can tell
17 you how SNF quality compares across various facilities. Or
18 you might be interested in the quality of care for patients
19 with strokes or congestive heart failure or hip fractures,
20 for example, and you need to think about this in designing
21 the systems.

22 A final issue is the method and frequency of

1 reporting. If you're, for example, monitoring quality to
2 develop early warning of problems that are developing,
3 you'll design the system differently than if your end goal
4 is to provide comparative data for consumers, probably.

5 In measuring the clinical or the technical quality
6 of care, we turn to the old standby structure process
7 outcomes measures that we've discussed in many contexts.
8 The paper provides some examples of these measures that
9 would be of interest in addressing the clinical quality of
10 various types of post-acute care. And it considers which
11 might be meaningful across different settings.

12 I think it's important to note that the structure
13 measures and the process measures are perhaps very clearly
14 suitable for many of the accountability or provider oriented
15 quality measurement functions. But in many cases, many of
16 the patient health and functioning outcomes we're interested
17 in really relate to care that's provided across settings.
18 For example, being interested in the outcomes of care for
19 patients with strokes, for example.

20 At the same time, though, many of the goals of
21 quality monitoring, as we know, are best served by provider
22 specific data or data that's more directly actionable.

1 The paper also describes some other dimensions of
2 quality that we might be interested in monitoring, but I
3 think that's pretty straightforward and I won't take the
4 time to summarize that information.

5 I think the question of what data we want to use
6 in a quality monitoring system is a really critical one to
7 spend some time on, in thinking about various quality
8 monitoring systems for post-acute care. The paper provides
9 an overview of five different types of data for monitoring
10 the quality of post-acute care, and some issues that might
11 be involved in doing so.

12 The first type of data that we want to think about
13 is claims data. At this point, we don't know whether post-
14 acute care claims data provide good information for quality
15 monitoring, particularly as we move to prospective payment
16 systems.

17 The obvious benefit of these data is that they are
18 already being collected in a standardized way and we have
19 them available. However, they don't offer much in the way
20 of clinical information.

21 MedPAC has recently issued a request for proposals
22 to conduct a feasibility study on the use of claims and

1 other administrative data to assess beneficiaries' use of
2 needed skilled nursing facility services. So this may
3 hopefully shed some light on this question.

4 A second type of data that we should think about
5 is medical records data. They're a rich source of clinical
6 information, obviously, but they are expensive to obtain.
7 An important benefit of their use is that you could imagine
8 building data sets that cross provider types for analysis of
9 patient care.

10 Another issue, in addition to their expense, is
11 however that there aren't right now some defined sets of
12 quality measures for Medicare that we can move forward to
13 implement in the short term.

14 Another type of data to think about is provider
15 certification data. We think that this source of
16 information could be better than it currently is. It
17 provides good structural information for quality monitoring,
18 but users of these data have noted problems with accuracy
19 and completeness.

20 Patient surveys are another source of data to
21 consider. The Medicare Current Beneficiary Survey provides
22 some limited information on post-acute care use and costs,

1 but there isn't a survey designed to obtain information on
2 patients' experiences and perspectives on post-acute care.
3 We know that characteristics of the population may, in
4 certain cases, present barriers to implementing such a
5 survey.

6 Finally, the patient assessment data. This, as
7 you know, is really the backbone -- patient assessment data
8 is playing a key role in both the payment and the quality
9 monitoring initiatives for Medicare's post-acute care
10 providers right now.

11 We're in a situation in which we've got, right
12 now, different data sets, either having been developed for
13 different providers or expected to be implemented. All of
14 these data sets provide some useful information about
15 patient status that can serve in quality measurement.

16 However, with each of the data sets themselves,
17 there are a number of issues that have been raised about
18 them. And then I think there's some very important issues
19 overall to think about, in making the decision about how
20 much we want to build on the quality front and on these
21 foundations.

22 For example, do we want to continue moving forward

1 with different data elements and repositories? What about
2 the burden on beneficiaries and providers associated with
3 multiple assessments in a single setting and when moving
4 between settings? Is there a better way to deal with those
5 problems? Moving forward with this, will we ever be able to
6 routinely compare outcomes in different settings? Will we
7 ever be able to develop a database that allows us to assess
8 patient outcomes that result from the cumulative effect of
9 care across settings?

10 As I said, I think each of the databases
11 themselves, there are issues with the data that are
12 developed. But I think the overall issues are also
13 important. And we know that HCFA is, of course, in the
14 process right now of testing the minimum data set for post-
15 acute care for potential use in inpatient post-acute care
16 settings. But it's not clear how this will play out, and we
17 can talk some more about that.

18 For commission discussion, this paper was designed
19 as an introduction to thinking about these issues in more
20 depth. I would suggest four questions that you might want
21 to consider in your discussion.

22 First, what should be the objectives for

1 monitoring post-acute care quality? Assuming that you
2 wanted to address multiple objectives, which of those do you
3 see as the highest priority and should be implemented first?

4 Next, as I said, I think the data issues are
5 critical. Should Medicare invest in collecting new or
6 different types of data or the development of quality
7 measures that could better use existing data? Should we
8 rethink or modify current data collection efforts or should
9 we continue to build on what we have?

10 Finally, I think it would be helpful for staff to
11 obtain some guidance on what direction you wanted to take
12 this analysis, in terms of what additional information would
13 be helpful to you as you consider refining your
14 recommendations about what it is that you want to achieve
15 from post-acute care monitoring systems.

16 DR. WAKEFIELD: I've only been able to give this a
17 cursory look, so I need you or somebody to tell me if I'm
18 wrong on what few facts I have. On page 10 in your
19 document, you were talking about staffing levels as a
20 structural issue or concerning the policy arena.

21 Here's my question, and let me just see if this is
22 correct. We have 44 RUGs. They were developed by HCFA

1 based on two very large studies of nursing and therapy time
2 -- nursing being registered nurse, LPN or LVN, and nurse
3 aide -- for each of those 44 RUGs and then an estimation of
4 the cost of care that would be associated with that provider
5 mix.

6 It's my understanding then that each facility
7 fills out a form regarding their RUG for particular
8 patients, there's an adjustment for region. It must be a
9 geographic region. There might be some other adjustments
10 I'm not familiar with.

11 My question is the payment rate based on a certain
12 staffing mix that was established based on those studies,
13 but there's no independent audit or determination of whether
14 or not facilities are actually staffing at that level that
15 that payment rate was originally based on.

16 If that's true, is that a concern for us, that a
17 payment was established based on a certain set of staffing
18 hours or parts of hours, from different levels of staffing?
19 Is that a concern, in terms of quality? And when we look at
20 changes in the payment methodology, will there be an effort
21 to staff down even further?

22 Obviously, most of the staffing we're talking

1 about, or I'm talking about here, in the skilled nursing
2 facilities is nursing care. So I'm just questioning why
3 there may not have ever been an expectation that those data
4 be audited or monitored in some fashion? It clearly wasn't
5 an issue, I guess.

6 MS. DOCTEUR: Could I clarify something, and
7 please tell me if I'm wrong, because I may be. RUGs go to
8 the payment use of the MDS and they focus more on the
9 quality indicator side of things.

10 But my understanding was that the RUGs are based
11 on the amount of time associated with the therapy, as
12 opposed to a direct measure of staffing.

13 DR. WAKEFIELD: Right, it is the amount of time --

14 DR. NEWHOUSE: I think you're going to the
15 determination of the weights, but those are relative. So
16 the real issue then becomes the conversion factor, I think,
17 is what you're talking about.

18 DR. WILENSKY: But I think there's also a more
19 fundamental question, which is was there an intent to
20 require certain input mix in providing a service? I don't
21 believe there was. There was an attempt to come up with the
22 costs, an approximation of the costs of providing a service.

1 But once you went to a bundled payment, one of the
2 advantages of having a bundled payment is that you allow for
3 some flexibility -- in a way what Carol was referencing with
4 regard to home care -- in which you allow agencies to
5 provide the service in various ways and then need to monitor
6 quality and outcomes measure.

7 But I think it would be -- I would regard it as
8 antithetical to one of the potential gains of going to
9 bundled payment, that you then say because we calculated the
10 base cost on certain inputs, that if you don't use that
11 input mix, you somehow don't get payment or get your hand
12 slapped or whatever.

13 DR. NEWHOUSE: No, but the issue is if you reduce
14 the staffing in response to the lump sum, then should the
15 conversion factor be reduced?

16 DR. WAKEFIELD: Yes, is there one set of payment
17 being made that's not consistent with the staff that are
18 being fielded? And is that a concern in terms of measuring
19 patient outcomes?

20 DR. WILENSKY: No, I think the question is, you
21 certainly want to measure patient outcomes and quality. But
22 having an input as the requirement is a very questionable

1 way to do it.

2 DR. WAKEFIELD: Part of my concern is -- and it's
3 the last thing I'll say about this, because obviously I'm
4 not very clear. When I was reading through this, and what
5 little I could ascertain about it, this discussion is
6 personally helpful for me.

7 The one concern I had was whether we're able to
8 measure outcomes adequately enough so that issues around
9 process and structure still matter until those outcome
10 measures are developed in a more refined fashion than it
11 might exist right now.

12 DR. WILENSKY: The whole reason we're having the
13 discussion, and had it before --

14 DR. WAKEFIELD: Right, so it gets me to that
15 point, because that's a proxy somehow.

16 DR. NEWHOUSE: A couple points. First, you raised
17 the issue about having different monitoring systems for
18 different settings and whether that's desirable. On the
19 face of it, the answer would seem to be no.

20 What would help me is if you could give some
21 indication of how much overlap there is in these various
22 systems? As far as I know, they all assess functional

1 status, for example, in some fashion.

2 So to what degree do they already -- I mean, is
3 this a matter of one's in Spanish and one's in French? Or
4 is this a matter of one's in Spanish and one's in Finnish?

5 MS. DOCTEUR: Comparing, for example, the MDS and
6 the FIM, and I've seen studies that tried to do crosswalks
7 comparing these things, the MDS, the FIM, and OASIS. There
8 are some very serious differences among them. They were
9 developed to do different things.

10 For example, the OASIS was designed for one
11 purpose, and that is to serve in an outcomes based quality
12 improvement system. The FIM was developed as a functional
13 measure for rehabilitation care.

14 The MDS is very different. It was originally
15 developed as a resident assessment or care planning tool
16 actually for nursing home residents in the long-term care
17 facility, and it's oriented primarily toward maintenance
18 issues.

19 So the three of them are designed to measure
20 different things. To the extent there is overlap, in some
21 cases, some things try to measure the same thing but do it
22 in a slightly different way, so they could ask the question

1 differently or have a different sort of scale.

2 DR. NEWHOUSE: My intuition is we need some common
3 set of elements, and then it seems quite likely that there
4 may have to be different elements that are specific to a
5 setting. I don't know.

6 But I think, in terms of trying to come to grips
7 this, it would be helpful to focus on what we think ought to
8 be collected for every setting, no matter where the patient
9 is, and if you could lay out what is now in the core and
10 maybe some options about what could be in the core

11 could be collected across all the settings.

12 MS. DOCTEUR: The MDS-PAC, as you know, is
13 designed to be something that could potentially be
14 implemented in the inpatient post-acute care settings.

15 DR. NEWHOUSE: But I don't know how that tracks to
16 OASIS.

17 The other issue you raised, which is certainly an
18 important issue, is what we think good quality care ought to
19 contribute to outcomes. I mean, that's an empirical
20 question. I assume we're not going to have an answer any
21 time soon to that.

22 But it does raise the issue of how much weight one

1 is going to put on change in outcomes in payment or other
2 incentives that may derive from quality monitoring. I think
3 it's an appropriate caution that you've raised, or is at
4 least implied here.

5 DR. MYERS: I'd like to address briefly the issue
6 of the various ways to monitor quality with the various data
7 systems. I think that the claims do have value and I'm
8 pleased that we're going to ahead as you've outlined in the
9 narrative with the RFP.

10 But I think ultimately we need to move towards the
11 electronic medical record. I think the data has become very
12 clear that the EMR has the potential to augment quality in a
13 significant way. Several studies now have demonstrated
14 that, at least in my mind, in an unambiguous fashion. I
15 think we ought to be providing for incentives in this
16 setting to move in that direction. And we should look at
17 the various advantages that the EMR has over claims data.

18 As an interim step, we ought to look at those
19 patients for whom pharmacy data is available, in addition to
20 claims data. I think there might be an interim role for
21 claims plus pharmacy.

22 There are a variety of things that you can learn

1 about quality, both the presence and the absence of quality,
2 with the pharmacy data in conjunction with the claims data.
3 And so we ought to not ignore that as a possibility.

4 But I want to stress the point that ultimately
5 what I think most health services researchers would like is
6 online, real time EMR. And we, I think, could play a key
7 role in encouraging that.

8 DR. KEMPER: I thought this was a thoughtful set
9 of materials and was glad to see also that it's slated for
10 the March report because I think with the payment changes,
11 particularly the home health payment changes, it will be
12 important to balance that with the quality discussion.

13 You asked about opinions about priorities. I
14 guess in your table one, my own opinion is that generating
15 information for providers and encouraging provider efforts
16 to improve quality would be the one that I would put first,
17 because that's the one that may have the greatest impact on
18 care delivered.

19 I also think it might be possible to combine that
20 with some annual reporting on those efforts, so that we get
21 some sense, and others gets some sense, of what's going on
22 in the quality area.

1 My second priority would be tracking changes in
2 post-acute care quality over time, a more general tracking.
3 I have Bill Curreri sitting on my shoulder saying no, no,
4 it's much more important to have an early warning system,
5 but I think that that needs to be ad hoc in response to
6 policy changes where they occur, the way we've seen in
7 response to the interim payment system and so on. A global
8 system to try to do that is infeasible.

9 I guess my third of the six priorities would be
10 develop the information for quality assurance, again because
11 of the direct implications for care and eliminating
12 egregious problems in care.

13 I guess the other comment I had was that I think
14 it would be useful in the materials and in the work that you
15 do to bear down, bore in more specifically on what HCFA's
16 doing. OASIS is designed for quality management, actually,
17 rather than payment, as you indicated. What are they
18 actually planning to do with it? Try to get some assessment
19 of the magnitude of the effort, so that we might be in a
20 position to make recommendation on what's going on, as well
21 as the SNF quality assurance and so on.

22 The last comment is really a question of whether

1 you've thought at all about the implications of using the
2 same data for payment that you're using for quality
3 assurance, and what the payment incentives are for data
4 reporting, and so on, and what that means for whether you
5 can believe the data for quality assurance purposes.

6 I haven't really thought that through but you
7 certainly have an incentive to upcode. Can you then use
8 that same information to monitor quality? And what are the
9 implications?

10 MS. DOCTEUR: I have thought about that. I think
11 it depends on the payment system design, obviously, as well
12 as how the data are used in quality. One example in which
13 I've been thinking about it is in terms of the OASIS.

14 In the OASIS, the health care provider goes in and
15 makes an assessment of the patient, in terms of that -- I'm
16 oversimplifying -- but in terms of how they perceive that
17 person's capacity to do something. For example, one item
18 asks about does that person have the capacity to dress him
19 or herself? It's not a performance based thing, in the
20 sense that you don't ask whether that person actually does.
21 You ask whether you think they have the capacity to do that.

22 In the next 60-day assessment you would ask the

1 same thing, and the outcome would be determined by whether
2 there had been improvement in that.

3 Since those same data are being used to determine
4 payment, it seems like the incentives maybe counterbalance
5 each other.

6 DR. NEWHOUSE: Why wouldn't the incentive be to
7 both code initially severe? Then you get more payment and
8 you get more improvement.

9 MS. DOCTEUR: To code severe in both cases?

10 DR. NEWHOUSE: To code severe initially.

11 MS. DOCTEUR: It depends on if it's ongoing. So
12 for your next episode, then you're --

13 DR. WILENSKY: But initially, the incentive is in
14 the same direction.

15 MS. DOCTEUR: For the first assessment, right.
16 Yes.

17 MR. MacBAIN: Beth, I think in the paper in a
18 couple places you allude to the difficulty of using outcomes
19 data as an accountability measure at the provider level. I
20 think that needs to be emphasized more strongly, that at the
21 accountability stage you can hold someone or a provider
22 organization accountable for how they're structured or for

1 what they do. But the outcome may be the result of things
2 totally outside their ability to control. And the
3 collections of outcomes data is crucial for purposes of
4 validating whether the structure and process measures make
5 sense on an aggregate basis but are not very useful as a
6 measure of quality when you get down to individual
7 providers.

8 And also divorcing that, as you do point out
9 rightly, divorcing that from accountability. It increases
10 the likelihood that you'll get good quality data because it
11 removes the defensiveness from reporting stuff that people
12 intuitively know that don't have a lot of control over.

13 DR. LOOP: There are some quality elements that
14 are in the annual licensure surveys of home health and
15 nursing homes, the state surveys sponsored by HCFA. So you
16 want to make sure you're not duplicating some of those
17 quality elements. I don't know how uniform that is around
18 the country, but there is an annual licensure survey.

19 The second point is that I would caution you not
20 to be too diffuse in trying to monitor quality, but to have
21 a somewhat narrow focus in certain areas. You might want to
22 study certain types of patients. For example, a big problem

1 is dementia in nursing home patients. Or the types of
2 treatments, for example mortality and morbidity related to
3 pharmaceuticals. The number of days by diagnosis and a
4 certain part of post-acute care, days in restraints, things
5 like that.

6 The other thing about quality is just a sort of
7 philosophical point. That is that quality is really best
8 done from the bottom up. If you can stimulate the various
9 elements of post-acute care to look at quality themselves by
10 comparing best practices and have quality indicators as part
11 of the management of the facility, where people really meet
12 and talk about it, and it's part of every subject.

13 These are just my comments in reading this.

14 MS. RAPHAEL: A couple of thoughts. From my point
15 of view, the greatest challenge in terms of monitoring
16 quality is whether or not the information leads to any
17 change in behavior, whether it's provider behavior or
18 consumer behavior. It's just always a challenge to somehow
19 take information, give feedback, and evolve.

20 So I guess for me, the product isn't another
21 report on quality. It's how are we going to do things
22 better a decade from now than we do them now? Whether it's

1 sic sigma or whatever process you use, to me that's a
2 fundamental question. It's a question at all levels of the
3 Medicare system.

4 So I am intrigued by whether or not you had on
5 this table developing information for beneficiaries. I'd be
6 interested in knowing more about whether or not
7 beneficiaries really use that information, whether they make
8 choices, whether or not it affects provider behavior in
9 terms of what they do when they know that beneficiaries are
10 looking at the results.

11 Also, I was interested in what Joe had asked about
12 because I think the issue of common elements in all of these
13 instruments is very important. We're seeing people coming
14 out of nursing homes much more rapidly, so they may be in a
15 nursing home only 10 or 15, and then they're being admitted.

16 Why do we have to start all over again with
17 another instrument? Is there no way to have something that
18 has common elements that we can use all together? So that's
19 just something I would like to better understand.

20 Then in your comments, I was also interested in
21 your saying that for people in nursing homes, the use of
22 proxies hasn't been terribly successful as a way to kind of

1 evaluate quality. That is a big issue in nursing homes.

2 I'd be interested in your thinking about how do
3 you get information on quality if you can't go to the
4 residents, if you can't go to the proxies? How are you
5 going to find out what you need to know?

6 DR. WILENSKY: I had a couple of comments, Beth,
7 that I want to add to this. The first has to do with
8 something where -- Carol really raised it, maybe in a
9 slightly different context. But that's the potential
10 commonality and some concern that I had that nowhere is
11 there a sense that, as we talk about different data sets and
12 different measures of quality, that we ought to think about
13 this in some sort of cost benefit analysis.

14 I think for a lot of reasons there has been a
15 tendency to not look at the costs or burden imposed on the
16 collection efforts with OASIS and the minimum data set,
17 particularly when it is quite possible that you will have
18 individuals who will be in and out of one type of facility
19 and into another type of facility in differing time periods.

20 And that while I strongly support data collection
21 so that we have some idea of what's going on and of being
22 able to set up more reasonable medical classification

1 systems, it has seemed to me that there has been a real
2 insensitivity as to the costs and burden imposed, and that
3 it is too often one additional piece of information,
4 irrespective of the costs imposed on the institution or the
5 providers involved.

6 And since I think, when you put these costs on,
7 you will take away from resources in both time and money
8 available for direct care, if for no other reason, that
9 becomes a much more serious issue.

10 So I would like to see, when we have discussions
11 of quality and monitoring, that there's just some
12 sensitivity to the fact that this stuff is not free in any
13 sense.

14 The second issue, I want to continue something in
15 the discussion Mary and I had with regard to say nursing
16 time, which was used as a way to develop a payment
17 mechanism, and whether we ought to think about process items
18 as proxies for quality.

19 One of the areas that, as you can tell by my
20 comments to Mary, I am always a little uneasy about taking
21 previous points in time ways of doing things, and assuming
22 that any deviation from that represents some deterioration

1 in quality. I think it just locks us into old practices,
2 not best practices, and I'm a big fan of trying to get
3 information and following of best practices.

4 What we might be able to do, however, is to think
5 about looking for whatever indicators of quality and outcome
6 concerns that we may be able to put into effect. And Floyd
7 raised a number of potential concern indicators. And at
8 that point, then to start going back to say if you've got
9 some kind of an intermediate concern, intermediate outcome
10 or intermediate input, that's showing a level of concern,
11 readmission or adverse drug response or falls or whatever,
12 at that point going back to look at staffing patterns seems
13 much more justifiable, rather than to demand, sort of
14 irrespective of what's being produced, that you're somehow
15 poor quality if you don't have an input mix that has X hours
16 of this and nine hours of that.

17 It's really sympathy to what Carol had raised
18 earlier, that one of the advantages of paying a payment by
19 episode is that your responsibility is to do a good job.
20 And if it means one visit or three visits that way and use
21 of some capital equipment or putting money into electronic
22 medical records so that you can easily compare across

1 patients and across facilities, that that might lead to
2 better outcomes.

3 Just thinking about it in that kind of context is
4 you get a signal of a problem, then there are all sorts of
5 things you may want to go back to, as opposed to starting
6 that if you don't have X amount of staffing by Y kind of
7 personnel, it's an indicator of a quality problem from the
8 get go.

9 DR. WAKEFIELD: I would just say, I certainly
10 agree with you. My question and concern is is the system
11 sensitive enough to pick up problems associated with that
12 stage of changes in staffing? Are our measures of quality
13 going to pick up things as fundamental as patient safety?

14 So I agree with you wholeheartedly not to come in
15 on the front end and say this is what you must have, or that
16 that should be mandated. That's not the point.

17 The point is how do we get at changes that may
18 adversely impact? We've got pressure on those systems as a
19 result of those payment changes.

20 DR. WILENSKY: But I think you just actually hit
21 it. If you see changes in fall rates, in decubitus ulcers,
22 that aren't associated with changes in case-mix indices that

1 it's not just that you have sicker patients, but adjusting
2 for any change in case-mix there are some kind of
3 indicators, readmission, adverse drug reactions, falls, to
4 say at that point -- and you don't say that that is by
5 itself an indicator of a bad outcome or bad quality. You
6 just indicate it as that ought to trigger a better look at
7 what's going on, as opposed to putting it at the get-go,
8 that this is how we're going to have to go.

9 My concern is because this is no longer an
10 abstract concern, since we've already seen some pressure, of
11 saying you don't have minimum staffing.

12 DR. NEWHOUSE: This is going forward to a chapter,
13 I suppose, but I'd like some attention devoted to the
14 integrity of these data and the ability to audit them. On
15 the inpatient side we took the chart as a gold standard and,
16 in effect, the whole auditing system was premised that the
17 chart was correct and we would audit a sample of charts.

18 I, at least, am not convinced in the face of it
19 that I have the same confidence as you move out of the
20 inpatient setting. And particularly if there's substantial
21 financial or other sanctions that are going to be based on
22 these data, that how are we ever going to know that these

1 data are, in fact, what they purport to be?

2 I don't have an answer to that question, in some
3 of these settings. But I think we ought to at least raise
4 the issue and, if there's something we can say about it,
5 terrific.

6 DR. WILENSKY: Any other further comments?

7 MS. DOCTEUR: Let me just say a couple things. At
8 the October meeting, as you'll recall, you saw presentations
9 and papers on some end stage renal disease quality issues
10 and some work relating to the peer review organizations'
11 quality improvement efforts, and the survey and cert quality
12 assurance work.

13 We had originally thought that that work, in
14 addition to this work on the post-acute care quality issues,
15 would form a chapter for our June report. We've since done
16 rethinking about that, largely based on the reaction to the
17 October paper, in which we very strongly heard the
18 commissioners say they were really interested in perhaps
19 thinking about issues in a cross-cutting way.

20 I remember some examples were thinking about the
21 relative merits of quality assurance versus quality
22 improvement and relying on Medicare.

1 So our current thinking, and I just want to let
2 you know that this is what our current thinking is, is to
3 have the cross-cutting issues in a chapter in June and have
4 some of the focus post-acute care quality monitoring
5 discussion in the March report, along with some of the
6 specific ESRD quality issues that were raised for March.

7 What that will mean, if you think that's a good
8 way to go, what that will mean is that we'll need to see
9 another paper on this stuff for December and then it will be
10 incorporated into a chapter in January. So let me run this
11 by you.

12 What I would propose bringing to you in December
13 then, to follow on to this, would be a focused look at what
14 HCFA is doing in each area, for home health, for SNFs, for
15 rehab, with a focused look at the data sets that are being
16 used in some of the data issues. And then we can take it
17 from there.

18 Is that the direction you'd like to go with this?

19 DR. WILENSKY: I think that sounds like a good way
20 to do it.

21 Let me open this to public comment? Does anyone
22 have any comments regarding our first two sessions?

1 MR. ELLSWORTH: Good morning, or good afternoon.

2 My name is Brian Ellsworth. I'm with the American Hospital
3 Association. Let me just make a couple of brief comments on
4 the home health PPS and then some comments on the quality.

5 With respect to the home health PPS, we're in the
6 middle of our deliberations now at this point, looking at
7 the proposed rule and intend to comment on it. One of the
8 concerns that's very clearly come through in our discussions
9 about home health PPS is the administrative load of these
10 systems and the burden already that these systems already
11 have with them, in terms of managing the data and the
12 information, things like the OASIS and the physician
13 certifications and so on and so forth.

14 We are hopeful that the promise of prospective
15 payment will be that there is some relief from those burdens
16 as the providers are given the tools to kind of manage the
17 care more effectively over the course of an episode.

18 Instead, what we kind of see is more complications
19 and more bells and whistles. So we're very interested in
20 pursing ways to kind of simplify and streamline the thing
21 and leverage the information that you get out of the case-
22 mix system to have, where you need complications have

1 complications and where you can simplify, simplify things.

2 But we're very concerned about the administrative
3 load of these systems.

4 The other point I would make about home health is
5 there is a utilization domain of the three components of
6 case-mix. There's clinical, functional status, and
7 utilization. The utilization domain has both indicators of
8 utilization prior to the home health episode and then during
9 the home health episode.

10 So there can be created both intended and
11 unintended consequences from using utilization in a case-mix
12 system. And that might be something that everybody wants to
13 look at, in terms of these concerns about stinting or those
14 kinds of issues. So I'd just kind of point that out as an
15 informational type of thing.

16 With respect to the quality system, the post-acute
17 quality issues, I would say a couple of things. I would
18 urge that, as MedPAC looks at this issue and studies this
19 issue, that they look at collaborative processes to improve
20 quality. We very much agree with the assessment that one of
21 the ways to -- it's very hard to kind of micromanage quality
22 improvement from the top. You have to kind of work it from

1 the bottom up. Government can really play a role in
2 bringing people together in kind of a voluntary best
3 practices collaborative framework and really improve quality
4 in so doing.

5 And that maybe MedPAC wants to study some of the
6 ways that that's been done in the past in almost kind of a
7 case study type of idea, and include some of that in the
8 report.

9 Secondly, as regards the commonality issue, we are
10 increasingly hearing from our members who are overseeing
11 integrated delivery systems that it is getting increasingly
12 difficult to figure out how to manage care across all these
13 silos and how to manage the information and the incentives.
14 Kind of a zero-based review of these data elements, in my
15 opinion, revolving around primary diagnosis, comorbidities,
16 functional status, and then from there kind of a very strict
17 cost benefit analysis of what further needs to be included
18 in looking across settings as kind of a common base, and
19 then recognizing that each settings have their particular
20 issues over and above that.

21 Thank you very much.

22 DR. WILENSKY: Thank you. Any other comments?

1 We will now break for 45 minutes. It's 12:30. If
2 we can try to reconvene at 1:15, we'll start the afternoon
3 session a few minutes late.

4 [Whereupon, at 12:32 p.m., the meeting was
5 recessed, to reconvene at 1:15 p.m., this same day.]

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1 AFTERNOON SESSION [1:28 p.m.]

2 DR. WILENSKY: We're ready to start the afternoon
3 meeting. I thought before we get into the first session, I
4 would ask Murray if he would introduce some new staff who
5 are here, so the rest of the commissioners know who they
6 are.

7 DR. ROSS: Gail's calling me on my atrocious
8 ability to do things in executive session, when we get too
9 carried away on other topics.

10 But since these are faces you're going to be
11 seeing over the not-too-distant future, let me introduce
12 three people who have started over the past couple of weeks
13 with us. Alphabetically, Matt Barry, if you could stand up
14 for a second and wave. Ann Moody, and Jennifer Thompson

15 DR. WILENSKY: Welcome aboard. Stephanie.

16 DR. MAXWELL: Thank you. With this presentation
17 I'll be switching gears a bit, compared to the other
18 presentations you've had today, that govern more specific
19 policy issues and analyses for your consideration.

20 Through this talk, many on the staff wanted to let
21 you know about a detailed analytic database that we are
22 building that will serve as a rich resource for several of

1 the Commission's shorter term and longer term research in
2 policy analyses, regarding particularly hospital services
3 and post-acute services in the coming year or two.

4 Conceptually, the concepts of the database that
5 we're building is extremely straightforward. We are
6 building a beneficiary level longitudinal or chronological
7 database on Medicare encounter information. In most cases,
8 the stream of information is triggered by a beneficiary's
9 acute stay in 1997. After the stay or after the first stay
10 for the beneficiary, our database picks up all post-acute
11 care and any subsequent hospital admissions that occur
12 within a minimum of one year past the triggering hospital
13 stay.

14 Of course, not every single encounter considered
15 to be post-acute actually is immediately preceded by an
16 acute hospitalization. The database also includes those
17 post-acute encounters that are not immediately preceded by
18 hospitalizations, as well.

19 I'll come back to details about the database, but
20 it's probably more important to mention up front why the
21 staff is building this file. Many current payment policy
22 issues about questions about seemingly comparable services

1 furnished across different settings and about appropriate
2 service use and payments at different settings throughout
3 the course of a beneficiary's illness or injury event.

4 Current policy discussions also invoke analyses
5 and comparisons of the pre- and post-BBA landscape.

6 Particularly regarding hospital and post-acute
7 care issues, our database will further the Commission's
8 ability to analyze and discuss very narrow or specific
9 policy issues as well as broader issues that span multiple
10 providers and health care encounters.

11 This slide lists some examples of issues that will
12 be analyzed using the files. MedPAC's hospital group will
13 need portions of the database in order to analyze the
14 hospital transfer policy enacted by the BBA. With the data,
15 the group can assess the transfer and discharge patterns in
16 place prior to the BBA, can model the impact of the current
17 transfer policy, can model the impact of expanding the
18 transfer policy to additional DRGs.

19 The analyses will also help, of course, to
20 determine future recommendations regarding the policy.

21 As you recall, the Commission also recommended
22 last year establishment of a transfer and short stay outlier

1 policy as part of the PPS for inpatient rehabilitation
2 services. Portions of this database are necessary for
3 analyses of transfers and discharges from the inpatient
4 rehabilitation setting, as well as from the acute hospital
5 setting.

6 Along those lines, and more generally, different
7 portions of the database will be used as staff members
8 assess various other BBA provisions affecting hospitals and
9 post-acute providers. Indeed, the assessment of the BBA
10 requires baseline characterizations of expenditures and
11 patterns of care that were in place before the BBA. The
12 database will be a major source of that information.

13 Looking beyond the BBA and onto longer term
14 hospital and post-acute policy issues, the database is also
15 needed by staff in order to analyze the quantitative aspects
16 of an option that some policymakers and researchers have
17 raised in the longer term. That is the option of bundling
18 post-acute payments with the hospital DRG payments.

19 The database is needed to identify and model
20 various links of post-acute time windows for that option and
21 to estimate the add-on payment to the DRG portion of the
22 payment, and to analyze particular features or options of

1 that policy, such as a partial bundled payment system.

2 The database is also needed to assess the overall
3 level of financial risk that hospitals would bear if those
4 were the entities that would receive the bundled payment.

5 Now any mention of the bundled payment policy
6 option begs a discussion of the political and administrative
7 or logistical issues that would need to be addressed to even
8 consider such a policy. On that score, I wanted to let you
9 know that the staff is initiating several discussions with
10 provider executives, hospital and post-acute executives,
11 around the country. These conversations will be followed up
12 with an all-day roundtable at MedPAC to work through some of
13 these issues, some of these more implementation oriented
14 issues.

15 There's a short appendix in the back of the paper
16 that discusses this, but we'll come back in later meetings
17 to discuss these more implementation oriented issues with an
18 eye toward including a chapter or section of a chapter in
19 the June report about that.

20 This database is also needed for several analyses
21 within just the post-acute area as well. As one example,
22 the database encompasses two years worth of home health

1 data, for those patients with hospital stays and for those
2 without.

3 Our databases in the past severely limited our
4 ability to analyze the long-term users of home health
5 services, and also our ability to analyze relationships
6 between hospitalization and home health service use.

7 Finally, the information in the files serves as a
8 readily available source of information for various
9 population specific analyses. For example, simply the
10 presence of prior hospital stays may yield added insights or
11 explanatory power in analyses of beneficiaries with diabetes
12 or ESRD.

13 Turning back to the database itself, I thought I
14 would just briefly describe the time span it covers, its
15 specific contents, and its advantages over our prior similar
16 databases.

17 This slide visually summarizes the time window of
18 the file. It consists of information on acute hospital
19 discharges and also selected outpatient discharges, such as
20 selected outpatient procedures, such as knee replacement,
21 that occurred during calendar year 1997.

22 In addition to '97 information, we have an

1 additional year, '98 information of post-acute data that
2 allows for episodes of care that began with hospitalization
3 in the later months of '97 and continued into '98. As you
4 can see, we also pick up some information in late 1996,
5 which helped us identify the source of admissions that occur
6 in the early parts of '97.

7 The file is comprised from information from
8 Medicare claims, cost reports, provider of service and
9 beneficiary files during these two years. I mentioned acute
10 and post-acute care encounters, but note that we're keeping
11 the psychiatric hospital and unit stays in the file, as
12 well. This is important not only for work on the acute
13 hospital transfer policy, but it also will help staff do
14 future work on psychiatric service use and policy issues.

15 The next three slides I'll go through quickly.
16 They simply summarize the type of data fields either
17 retained or created in the database. On this one we see
18 some basic beneficiary characteristics that are available to
19 us in the Medicare data.

20 On the next slide, we list the encounter oriented
21 information. Some of these variables are straight from the
22 claims and some of them we create during the database

1 development process.

2 This slide lists the type of financial variables
3 related to patient encounters that are in the file, as well
4 as provider characteristics such as profit status and chain
5 versus independent status will be included, as well.

6 Finally, I wanted to mention that I know that this
7 database work is somewhat familiar to those of you who were
8 commissioners in ProPAC. ProPAC created post-acute
9 databases like this three times in the past, once with 1991
10 data, one with 1994 data, and one with '96 data.

11 Some of the research off of those files are
12 summarized in the June 1996 report and the June 1998 report.
13 The research off of that built and substantially contributed
14 to the knowledge base about patterns of post-acute use among
15 Medicare beneficiaries.

16 As we move forward in the analytic agenda and
17 address new issues and evolving policy issues, though, we've
18 had to add more bells and whistles to the episode database
19 concept.

20 This last slide summarizes some of the issues that
21 we'll be able to better analyze because of some technical
22 enhancements we've made to the file. In particular, we'll

1 be able to more fully analyze the home health use and, as I
2 mentioned, patterns of hospitalization in relation to home
3 health use and to other post-acute encounters. We'll also
4 be adding outpatient therapy service use to the file and
5 we'll be able to analyze the interaction between that
6 service use and other post-acute service use.

7 Finally, we're adding more detailed financial
8 variables to the database, as well as a few more
9 characteristics from Medicare's enrollment and provider
10 service files.

11 I'd like to stop there and yield to any questions
12 or discussions you have today, although I know we'll look
13 forward to future meetings and some very interesting
14 discussions that will be filled up with analyses and
15 insights gleaned to this endeavor.

16 DR. WILENSKY: Stephanie, I had a question. I
17 think it was answered at the end of the paper, but I wanted
18 to be sure I understood.

19 Although the hospitalization triggers the event,
20 will this file be equally useful in analyses that we want to
21 do looking at substitutions or movements across different
22 types of post-acute care?

1 DR. MAXWELL: Yes.

2 DR. WILENSKY: My personal interest is more toward
3 looking across post-acute than to bundling the hospital with
4 the post-acute. I guess if we could resolve the issue of
5 how to have common payment, common assessment, common
6 quality monitoring across the various types of post-acute,
7 and get that problem fixed, I'd be game to think about
8 broadening the bundle vertically to look at Medicare
9 hospital versus post-acute.

10 I'm much more concerned about the horizontal
11 movement than I am about the vertical movement. Not that I
12 don't think it's a problem, I'm just more concerned about
13 where we go horizontally.

14 DR. MAXWELL: Let me add just that the
15 hospitalization for many of the beneficiaries create
16 somewhat of a starting point for looking at the stream of
17 post-acute encounters across all of the settings. Of
18 course, that's not the case with every single post-acute
19 encounter.

20 It is, of course, with the SNF encounters because
21 of the requirements to be in the SNF. And it is with most
22 of the long-term hospital and rehabilitation facility states

1 but not all. Absolutely all of the information will be in
2 the file, regardless of whether or not they had prior
3 hospitalizations, and it can be analyzed completely separate
4 from the hospital stay.

5 DR. WILENSKY: You gave the percentage with regard
6 to some things that were initiated by hospitalization, but
7 the two, I think, that are sort of the most interesting,
8 home care and rehab, you alluded to the fact that they
9 weren't as often triggered by -- do you actually know --

10 DR. MAXWELL: Yes, with the rehabilitation stays
11 and the long term hospital stays both, between 75 and 80
12 percent are preceded by an acute hospital stay within the 30
13 days prior. I don't have, on the tip of my tongue, what
14 share of --

15 DR. NEWHOUSE: About 50/50 for home health.

16 Stephanie, I'm very supportive of the database and
17 look forward to the results from it. My one suggestion to
18 you is that you also include the 1998 hospitalization data.
19 I understand you're not going to have two years worth of
20 runout, but that would let you look at '98 differed from
21 '97, either on the hospital size or on the short term post-
22 acute use side.

1 DR. MAXWELL: We can easily add that.

2 DR. KEMPER: I'm glad that you're going to be
3 looking at the bundling in more depth, and I hope that
4 you'll develop some expertise within the staff as well as
5 the contractor on it. One issue that that wasn't addressed
6 there, which seems to me to be very important, is the issue
7 of hospitals that own their own home health agency or a SNF,
8 and the issues of sort of in-house versus out-of-house
9 referral within the bundling and what incentives that
10 creates. It seems to me that's an important issue to
11 address in this whole discussion.

12 In that regard, there is some literature in the
13 anti-trust area about extending monopolies into other
14 sectors, that might be relevant to that analysis and it
15 might be worth looking at that.

16 With respect to the database --

17 DR. ROWE: You want to emphasize that a monopoly,
18 per se, is not bad. It's only if it's anti-competitive.
19 It's only under those conditions that it's unlawful.

20 DR. KEMPER: The database looks like a good
21 advance, and I guess one question I had, a concern I had was
22 the symmetry of the database, where you're following

1 everybody for a year forward, but you're only looking back
2 for a couple of months from the year. I think it might be
3 worth looking at whether you can look at a full set of
4 episodes that's representative, particularly these ones that
5 don't start with hospitalizations that may have started in
6 the prior year.

7 So thinking through what the implications are with
8 respect, whether you have a representative cross section of
9 all these episodes, given that it's not symmetric on both
10 sides of that year. And the definitions maybe of starting
11 an episode aren't symmetric either.

12 DR. ROWE: Stephanie, I wondered whether or not
13 the patient encounter information was going to include, or
14 would include as it's currently designed, utilization of
15 preventive services such as mammograms, flu shots, Pap
16 smears, colorectal screening, et cetera? Because sometimes
17 the way the database is constructed, those kinds of
18 encounters, which are not really diagnosis related, don't
19 get captured. And I think it would be very good if we
20 could, going forward, capture that information in a more
21 systematic fashion.

22 One of the problems in this area has been that

1 we've had inadequate information. Every time we want to
2 find out who's getting flu shots, you have to do another
3 survey.

4 DR. MAXWELL: We had lots of discussion on the
5 staff about the more ambulatory and outpatient oriented or
6 the more full beneficiary oriented prospective, and also
7 balancing the competing needs to start small and get geared
8 up. There are certainly some of the staff that will be able
9 to take this information and link it with some of the
10 physician files and the outpatient files to get exactly what
11 you're talking about.

12 DR. LOOP: What is the definition of an episode of
13 care? Where does it start and when does it end? For
14 example, if a patient has a stroke and is admitted to a
15 hospital, goes to a rehab facility, gets pneumonia,
16 transferred back to the hospital, develops respiratory
17 failure, receives a tracheostomy and ends up in a long-term
18 ventilatory LTAC facility, where is the episodes of care?

19 DR. MAXWELL: My answer to this is mushy but I
20 actually think it's the best answer. The length of the
21 episode or the nature of the episode will depend on what the
22 specific question that the analyst would be looking at. For

1 example, if someone is simply looking at home health
2 episodes, they might consider an episode to be the beginning
3 of a home health claim and continue until there is a break
4 in home health services. That would be completely
5 regardless of any hospital stays or any other event with the
6 patient.

7 From the prospective of certain hospital analyses,
8 the episode would begin with a hospital stay and go only a
9 couple of days or a week if someone is looking at the
10 transfer policy. It could go maybe a week or six weeks if
11 somebody is looking at bundling options. Because the file
12 is basically a chronological stream of claims for the
13 encounters, you can start it and stop it at different places
14 to suit the research.

15 DR. LOOP: But the way you're explaining it is
16 more by site than it is by diagnosis or treatment or change
17 in the clinical picture. And I think whatever it is, we
18 ought to state it up front, exactly what the episode of care
19 is, or how you're going to define it.

20 DR. MAXWELL: For many of these patients it
21 certainly starts with the hospitalization within the
22 construct of the file. But there are other analyses that

1 would use the file that would not start with that, that
2 would precede any hospitalization.

3 Sorry for the mushiness, but the capabilities are
4 there to create episodes to fit the need for the analysis.

5 MR. MacBAIN: A couple of questions. One is, do
6 you anticipate this is something that will repeat year after
7 year? Do you see this being refreshed with new data each
8 year?

9 DR. MAXWELL: I'm not sure if it would be fully
10 repeated on every single year, but certainly, just as this
11 is building off of similar work from the prior commissions
12 that had done it with base years every couple of years,
13 absolutely, it can be repeated.

14 MR. MacBAIN: The other question is, looking
15 forward, if there are subsequent generations of this, would
16 it be worthwhile including HMO encounter data, as well, to
17 provide an additional cross-site comparison?

18 DR. MAXWELL: Yes.

19 MS. ROSENBLATT: Just picking up on that. We're
20 always saying that we don't have enough data, so I think
21 doing this is wonderful and I'd sort of like to think of
22 this as phase one, where we'd be adding maybe HMO encounter

1 data and the ambulatory data and going on from there.

2 I want to make sure I understand, when you use the
3 word claim, are we picking up both what Medicare pays as
4 well as what Medicare does not pay? So that we're getting
5 all of the care to a given individual?

6 DR. MAXWELL: The information in the claims lists
7 the dollar amount, usually that the program pays, and there
8 is information there on the applicability of deductibles and
9 co-pays. We are picking that up.

10 MS. ROSENBLATT: The third thing is just another
11 element, and I don't know if it's possible to add it, but as
12 I was reading through it, I thought it might be interesting
13 to also include, along with the beneficiary information, if
14 that beneficiary has a Medigap plan and what plan.

15 DR. LEWERS: Just about your panel. I trust
16 they're going to be broad based with representation. For
17 instance, are we going to have practicing physicians? I
18 recognize there are physicians who are CEOs around, and
19 COOs. But I would hope we have practicing physicians.

20 I mean, you've got physical medicine, rehab, home
21 health physicians, primary care physicians that are involved
22 on a day-to-day basis, and I think they'd be important in

1 that panel. So whoever your contractor is.

2 And if you could help me on the file sources for
3 the data, selected outpatient procedures. You have knee
4 replacement. Can you explain that? I don't think knee
5 replacement is done as an outpatient. Are you talking
6 arthroscopy?

7 DR. MAXWELL: We have heard providers say that
8 some knee replacements are done on an outpatient basis and
9 then go on to SNF and rehab stays. I have no idea of the
10 prevalence of that, but we will pick it up if it's there.

11 DR. ROWE: Knee replacements on an outpatient
12 basis?

13 DR. MAXWELL: Yes.

14 DR. LEWERS: I'd check that source. I for sure
15 would get a practicing physician involved in that one. I
16 don't think that's the case. You better check that. If
17 anyplace would do it, Cleveland Clinic would do it. Right,
18 Floyd? You don't do those?

19 DR. LOOP: No, we don't

20 DR. WILENSKY: Let's move to the disenrollment
21 patterns in Medicare risk plans. Janet and Scott?

22 MS. GOLDBERG: Before I start, I just wanted to

1 note I put two additional slides by your folders. Those are
2 to replace tables four and five that I sent you in the
3 mailing materials. That goes in slot D.

4 HCFA published a final rule back in July of '98
5 regarding the establishment of the Medicare+Choice program.
6 The rule requires beneficiaries to remain in the plan for at
7 least 30 days before disenrolling. However, a lock-in is
8 going to be phased in over a two year period starting in
9 2002. That will limit enrollment and disenrollment to only
10 once per year.

11 The 2002 lock-in permits beneficiaries to switch
12 plans once within the first six months of the year but then
13 they cannot switch plans again during the rest of the year.

14 In 2003, beneficiaries can switch plans once
15 within only the three months of the year.

16 To assess the potential impact of these changes,
17 we decided to look at voluntary disenrollments from
18 Medicare+Choice risk plans. Specifically, we assessed
19 beneficiary and plan characteristics related to voluntary
20 disenrollment for risk plans and determined which
21 beneficiaries may be affected when disenrollment is limited
22 during the first and second quarter in 2002 and during only

1 the first quarter starting 2002.

2 We studied aged and disabled beneficiaries
3 enrolled in a Medicare+Choice risk plan as of January 1st,
4 1998. So it's basically beneficiaries excluding ESRD. A 5
5 percent randomly selected sample from the group health
6 master file provided data on beneficiary enrollments and
7 disenrollments.

8 Information on beneficiary and plan
9 characteristics was obtained from a variety of sources,
10 including the eligibility database, the area resource file,
11 and the Medicare Compare database. 1998 data was used
12 because this is the most recent full year for which data is
13 available.

14 The study cohort was followed from January to
15 December '98 to determine which beneficiary and plan
16 characteristics were related to beneficiaries' disenrollment
17 from plans and to simulate what would have happened if the
18 2002 and 2003 open enrollment rules had been in effect in
19 1998.

20 Disenrollments were counted as voluntary unless
21 the beneficiary died, moved to another county, or their plan
22 was terminated. If two plans merged and the beneficiary

1 remained in the merged plan, then we didn't count that as a
2 disenrollment. Beneficiaries were classified as voluntary
3 or involuntary disenrollees according to their first
4 disenrollment in 1998.

5 The plan and market characteristics that we
6 assessed were based on the plan that a beneficiary was
7 enrolled in and the county that a beneficiary was living in
8 as of January 1st, 1998.

9 The beneficiary characteristics that we looked at
10 were age, race, sex, institutional status, Medicare status,
11 working aged status, and enrollment background.

12 With respect to enrollment background
13 beneficiaries were classified into four categories. New, if
14 the beneficiary was new to the Medicare managed care program
15 as of January 1st, '98; continuous if the beneficiary was
16 enrolled in the same plan from December of 1997 to January
17 of 1998; plan switchers if the beneficiary switched plans
18 between December '97 and January '98; and gaps in
19 Medicare+Choice enrollment if the beneficiary was not in a
20 risk plan during December of '97 but had been in a risk plan
21 at some point in time prior to that month.

22 The plan characteristics that we looked at

1 included county level of urbanicity which classified as
2 large, metro, small metro or non-metro; county and
3 Medicare+Choice capitation rates; the number of Medicare
4 risk plans in a county; plan type which included IPAs, staff
5 HMOs and group HMOs; the Medicare market share of a
6 beneficiary's plan, which we calculated by dividing the
7 number of members in a beneficiary's plan in that
8 beneficiary's county by the total number of Medicare+Choice
9 risk plan enrollees in that same county; and we also looked
10 at the Medicare managed care penetration rate for a county
11 which was calculated by dividing the number of Medicare risk
12 plan enrollees in a specific county by the number of both
13 risk plan and fee-for-service beneficiaries in that same
14 county.

15 This table provides a general sense of the timing
16 of disenrollments. The unit of analysis here is the
17 disenrollment. Since some beneficiaries voluntarily
18 disenrolled more than one time during 1998, the sums for
19 each of the columns pertaining to voluntary disenrollments
20 are slightly greater than the percentages of aged and
21 disabled beneficiaries voluntarily disenrolling during '98.

22 About 15 percent of aged beneficiaries and 20

1 percent of disabled beneficiaries voluntarily disenrolled
2 during '98. The percentage of aged beneficiaries
3 voluntarily disenrolling was only about 1 percent higher for
4 the first quarter, compared with the second, third, and
5 fourth quarters if you exclude disenrollments on the last
6 day of the year. The percentage of disabled beneficiaries
7 voluntarily disenrolling was about 2 to 3 percent higher
8 during the first quarter, compared with the other quarters
9 if you exclude disenrollments on the last day of the year.

10 For the beneficiary characteristics that we
11 assessed, voluntary disenrollments were more common for aged
12 beneficiaries who were not institutionalized or who were
13 receiving Medicaid.

14 Non-institutionalized aged beneficiaries were 9
15 percent more likely to disenroll voluntarily compared with
16 those who weren't institutionalized. Aged beneficiaries
17 receiving Medicaid were about 8 percent more likely to
18 disenroll voluntarily compared with those who weren't on
19 Medicaid, but this difference was about 4 percent for the
20 disabled.

21 Of the plan characteristics that we assessed, only
22 level of urbanicity seemed to be related to voluntary

1 disenrollment. Voluntary disenrollments of aged
2 beneficiaries were about 10 percent higher in non-metro area
3 compared with large metro areas, and about 5 percent higher
4 in small metro areas compared with large metro areas. This
5 trend was similar for disabled people.

6 This slide displays characteristics of risk plan
7 enrollees potentially affected when open enrollment rules
8 change in 2002, and again when they change in 2003 based on
9 our simulations using '98 data. This table and the next one
10 that we present exclude involuntary disenrollees.

11 Of the beneficiary characteristics that we looked
12 at only institutional and Medicaid status appeared to have a
13 substantial effect on the likelihood that a beneficiary will
14 be affected when the rules change. Institutionalized aged
15 beneficiaries were about 5 percent less likely to be
16 affected when open enrollment is limited to one
17 disenrollment during the first quarter. Aged beneficiaries
18 on Medicaid are about 6 percent more likely to be affected
19 when open enrollment is limited to once during the first
20 quarter compared with those who are not receiving Medicaid.
21 This difference was about 4 percent for disabled
22 beneficiaries.

1 For the plan characteristics that we assessed,
2 only level of urbanicity seemed to be related to the
3 likelihood of being affected when the open enrollment rules
4 change. But even this effect was really small.

5 Disenrollments on December 31st accounted for the
6 difference in the geographic trend that you see on this
7 table and the table that we showed you before. This table
8 is different from the other one because beneficiaries'
9 ability to voluntarily disenroll on December 31st will not
10 be affected when the open enrollment rules change.

11 In light of the data we've just presented, we'd
12 like the Commission to consider whether there seems to be a
13 cause for concern about the future open enrollment changes.
14 And if the Commission thinks that these data indicate a
15 cause for concern, then we'd like you to discuss where we
16 should focus future research efforts.

17 DR. NEWHOUSE: I have a concern with the
18 fundamental logic behind this analysis that I'd like you to
19 say something about which is, I think the premise is that
20 the bigger the number, the more I should be concerned about
21 some group. But I'm not sure I buy that, or you should tell
22 me what I should make of the size of the number.

1 For example, you have some data that you didn't
2 present in the slide that show the working aged are
3 marginally more likely to disenroll than the non-working
4 elderly, but I'm not sure I should be more concerned about
5 the working elderly being locked in. Then some data you did
6 show shows the non-institutionalized are much more likely to
7 disenroll than the institutionalized, but there could be a
8 much bigger effect in the 5 percent of the people that are
9 institutionalized that will be affected than the 14 percent
10 of the non-institutionalized.

11 So I'm not sure at the end of the day what to make
12 of these numbers.

13 MS. GOLDBERG: Most of the percentage differences
14 are pretty small.

15 DR. WILENSKY: I think one of the real questions
16 is, what's the problem we think we're trying to find here?

17 MR. MacBAIN: I suppose if the problem were one of
18 adverse selection or favorable selection, and healthy people
19 are all disenrolling so let's lock them in for a while, then
20 the smaller the numbers, the less impact this policy is
21 going to have, so it might be discouraging. On the other
22 hand, it's encouraging if it doesn't inconvenience too many

1 people. So I'm not sure what to make of it either.

2 DR. NEWHOUSE: Except we know that disenrollees
3 are disproportionately the sicker.

4 MR. MacBAIN: Yes, leaving the healthy ones
5 behind, right. But either way, the point is, are we
6 stopping something that we don't want to stop?

7 DR. NEWHOUSE: But we don't know how that plays
8 within all the categories.

9 MR. MacBAIN: A couple questions on the data. One
10 is, how does HCFA treat December 31st disenrollment? Is
11 that a fourth quarter or a first quarter disenrollment?
12 Because that's significant because 5 percent disenroll on
13 the 31st. That seems to be the favorite day to disenroll.
14 If that is treated as a fourth quarter disenrollment and is
15 prohibited going into the future, that will be a problem.

16 Secondly, do we have any idea why that date is
17 favored? My first guess is that it would be related to
18 employer-provided benefits for retirees, and the lock-in
19 that employers may impose on the supplemental side of
20 things, which again could be a real problem if that no
21 longer can happen on the 31st because it's treated -- even
22 though it's really a January 1st, it's being treated as a

1 fourth quarter change.

2 Then related to that is a third question. It's
3 not in any of your cuts of the data, and that is whether it
4 would be possible to look at the effects of the lock-in on
5 people who receive supplemental benefit through a former
6 employer versus those who do not. To find out, for
7 instance, how many people who are changing in the third or
8 fourth quarter, other than the 31st of December, have the
9 date on which they can make a change determined by their
10 employer because their employer happens to have an October 1
11 open enrollment date for changing your supplemental carrier.

12 MS. GOLDBERG: For the December 31st question, I
13 was thinking about the question that you raised, and that
14 was why in the first table that I presented I broke out the
15 people that disenroll on December 31st. Then I specifically
16 excluded them from the last few tables because I thought
17 that they shouldn't be counted as the last quarter if the
18 open enrollment period is -- if the rules are so that if
19 they disenroll on that last day of the year, it doesn't
20 matter in terms of them exceeding the limit.

21 MR. MacBAIN: My question is, how is HCFA counting
22 that? Are they treating that as a first quarter

1 disenrollment or a fourth quarter disenrollment?

2 MS. GOLDBERG: I think it would be counted as a
3 first quarter.

4 DR. HARRISON: I think it's not counted at all.
5 You're allowed to disenroll December 31st with no charge.

6 MR. MacBAIN: What's causing that? Why is that
7 the favored date?

8 MS. GOLDBERG: The benefits that people are --
9 when people get offered their packages for the next year and
10 the people that are in their plan see what those packages
11 are for the upcoming year, they'll leave on that last day in
12 December.

13 MR. MacBAIN: So it's the change in the overall
14 benefits offered by the health plan.

15 MS. NEWPORT: That goes to basically where I was
16 going to start with my comments is that there's several
17 drivers for changes. We have to make the assumption that on
18 the level of change, December 31st for effective in a new
19 plan on January 1 is primarily driven by changes in a
20 benefit package which can only take place -- or
21 significantly for all plans can take place at that time of
22 the year. There are mid-year benefit changes that could

1 drive other switches and disenrollments -- not
2 disenrollments because plan changes have to be positive, but
3 there are drivers like that.

4 I think I would, depending on the time of the
5 year, you're going to have to look at this in terms of the
6 benefit changes that leads to plan switching or even may
7 lead to disenrollment. That's a benefit change as opposed
8 to a health status indicator necessarily. Potential
9 provider changes, provider contracting changes. We know
10 people sometimes will follow their provider who has
11 contracted with another entity, and in some areas, that may
12 have an effect on your numbers.

13 Then the numbers I found were interesting I think
14 -- I don't know if you had a chance to do this yet but may
15 be worth looking at is, changes in state law or differences
16 in state law, that may be more accurate, could drive some of
17 this. People do qualify for Medicaid and they'll go off
18 again. The data on that and I understand the transactional
19 linkage to HCFA is pretty good, so I think that may drive
20 some things.

21 Now having said that, a couple comments. I have
22 seen some data recently which I don't have with me which

1 I'll give you which might expand on this a little more. But
2 I would also suggest that of your demographic data, one of
3 the weakest areas -- and I speak from experience in terms of
4 our reconciliation process when we look at working aged --
5 the data has been correct, and incorrect, and corrected
6 again, on and off. I don't know what your window for this
7 data was. I would take a look at that because that may not
8 be helpful to your analysis.

9 The other thing is, there have been some studies
10 that may be worth looking at in addition to one of the
11 studies you cited, the OIG study, that may give more depth
12 to the analysis, because I think that OIG study that has
13 been criticized because it was so narrowly focused and very,
14 very narrow focus and methodology that people have been
15 concerned about.

16 DR. KEMPER: I guess I just want to echo some of
17 the earlier comments about the meaning of the numbers. I
18 would be more interested in what we could learn about the
19 reasons for disenrollment. If people are just gaming the
20 system to switch to traditional Medicare when they need an
21 operation or whatever, that's one thing. If there's a real
22 disenrollment for concerns about quality, that's another

1 thing. So maybe review of the literature, reminding us what
2 is known about that would be helpful.

3 The second thing is, I guess one question is,
4 what's the implication for the health plans of these new
5 rules? Obviously, there are implications for risk
6 selection, but I remember in the discussion of PACE and
7 social HMO there was some concern about attrition due to
8 mortality in these very sick caseloads or enrolled
9 populations. So some discussion of whether there's an issue
10 from the plan perspective would be interesting.

11 I guess my last question is if you could give us
12 some feel for where you are headed with this in terms of the
13 report and possible recommendations. What your thinking was
14 about where you were headed with this.

15 DR. HARRISON: I think we found that the numbers
16 didn't show very much to be concerned about. But what we
17 might want to look at more is the Medicaid interaction with
18 the managed care plans. Could be that state Medicaid laws
19 are affecting when people go in and out. Maybe people don't
20 understand when they enroll at first because of the
21 interactions and they may be disenrolling because of that,
22 because the Medicaid rate was the one that really stuck out.

1 DR. KEMPER: I wondered about that. So your
2 interpretation of why that might be is some kind of state --

3 DR. HARRISON: It could be that duals are confused
4 by the benefit interactions and once they realize, wait a
5 minute, can I get most of this stuff free on the fee-for-
6 service side anyway, why am I here? There could be some of
7 that. So I think we would want to look at that and see what
8 the interaction is between Medicaid and Medicare.

9
10 DR. KEMPER: Is there a Medicaid managed care that
11 might be interacting?

12 DR. HARRISON: There is Medicaid managed care, but
13 when you go into Medicaid managed care you do not give us
14 your Medicare entitlement.

15 MS. ROSENBLATT: I had a similar concern to Joe.
16 To me, the reason for putting in the lock-in was to minimize
17 the adverse selection to the Medicare program and to Medigap
18 plans due to this disenrollment.

19 So the key issue to me, and the OIG study as just
20 mentioned in the appendix is, do these lock-ins truly have
21 an impact on the amount of adverse selection that would be
22 hitting the Medicare fee-for-service program? I'm a little

1 bit concerned about only looking at the effect on the
2 beneficiaries who might be affected by it without looking at
3 the other side which is, what is the cost to the program, is
4 a little bit of an unbalanced look.

5 DR. LAVE: I think I really have the same sorts of
6 concerns about what one makes about numbers when you don't
7 know whether or not in fact a big number is good or bad.
8 Clearly, there was a sense that there are reasons for the
9 lock-in, which I don't think are here. One reason for the
10 lock-in is, if you're going to manage, you need to have a
11 population to manage, it seems to me, in addition to the
12 adverse selection. But if people can pop in and pop out, it
13 does indicate that the concept of management becomes a
14 little bizarre.

15 So I don't know whether the 5 percent or 8 percent
16 is big or low, and I would just want to support what other
17 people have said. I think that the critical issues are the
18 conflict with working aged policies. You want to make sure
19 that those things in fact are aligned.

20 DR. NEWHOUSE: Conflict with what?

21 DR. LAVE: With the employer -- the timing on the
22 decisions an employer makes with respect to what in fact is

1 going on. The conflict with going on and off Medicaid, and
2 what that means for people who are on managed care plans.
3 Then I think the other issue, what I had heard sometimes is
4 that some people who were in plans with drug limitations
5 would switch when they ran out of the drug benefit and then
6 they would move into another plan.

7 So I don't know what these numbers mean. I think
8 there should be a clear articulation about what one believes
9 the problem is that you are trying to address by looking at
10 these particular numbers, and whether these numbers give us
11 any insight into that. Absent that issue, it strikes me
12 that the best way of looking at what problems are, or to
13 have a beneficiary survey that indicate whether or not
14 people are just feeling screwed because they are locked in,
15 that would give me more information than I think this kind
16 of information would.

17 DR. LOOP: In your preliminary analysis, did you
18 look at disenrollment by geographic location? For example,
19 we noticed in our hospitals in Florida there are what
20 appears to be older and more chronically ill Medicare+Choice
21 patients in Florida than there are in Ohio. And there's a
22 greater density of enrollment in Florida, so there's a lot

1 more consumer information about these plans. There's also a
2 much higher rate of disenrollment than there is in Ohio.

3 You may find this is true on a larger scale and
4 that may lead you to a better analysis of the type of
5 patients that are enrolling and disenrolling by severity.
6 And it may lead you into issue of provider quality, because
7 I'm sure some disenrollment is related to provider or even
8 payer qualities.

9 MS. GOLDBERG: We have the disenrollment data by
10 state and I have a printout of that on my desk. I didn't
11 summarize it here but we definitely have it to do it.

12 As far Judy's question, the benefit package data
13 isn't in an analyzable form right now. I wanted to do it,
14 but you can't do it the way that the data are coded now.

15 DR. LAVE: I understand that. But that certainly
16 is one of the rumors in fact that one hears about why it is
17 that people disenroll.

18 MS. GOLDBERG: HCFA's doing a survey which will
19 answer a lot of the questions that you're raising.

20 MS. NEWPORT: There are instances in different
21 markets where, Judy, you're absolutely right. People hit
22 their pharmacy cap and then go to another plan and they

1 start over in the middle of the year with their pharmacy cap
2 with that other plan. So I think that initially the issue
3 with the lock-in was to take a look at the perception that
4 there's the adverse risk selection. But as the market share
5 has grown in managed care, +Choice plans, I think that
6 effect may have been moderated and now the drivers are more
7 closely aligned with this benefit package, the mobility also
8 of the providers from plan to plan. Again some markets -- I
9 can show you an exception to every rule probably on this,
10 but I think we have to take a look at that.

11 To go back to the working aged piece, there's two
12 issues here. One is the working aged who are individually
13 enrolled who happen to work. There are those who are
14 retirees, and as employers shop around for better benefit
15 packages on an annual basis, lots of them do RFPs on an
16 annual basis, the switching there may be because that
17 managed care plan is no longer offered by their employer.
18 So there's two levels of issues.

19 My concern with the working aged files on
20 individuals that are still working as opposed to when a
21 retiree plan is I think that data is very soft. So I just
22 think there's a multitude -- and the difference here in the

1 data, we're not sure if it's important or not.

2 But I think one of the things that we've found
3 over time is having -- part of our efforts are based in
4 trying to retain membership. As a company that does that,
5 we're very interested in keeping our disenrollment very low.
6 There's a lot of reasons behind that, contrary to everybody
7 else's view of the industry on some of this, and I think
8 that's important to look at that, and then slice it a little
9 differently because I think it's very -- it's a strong
10 consumer protection if they can vote with their feet.

11 We use that as a very formative measure of our
12 success in terms of what we're offering and our quality and
13 everything else. We want to keep people from voting with
14 their feet. So by removing that potentially -- the choice
15 that consumers have to go someplace else if they're not
16 happy, we think may in the end be very destabilizing to our
17 members.

18 DR. ROSS: I actually have a question for Janet.
19 For members who are incoming throughout the course of the
20 year, are they facing essentially the same annual deductible
21 and/or cap on their pharmacy benefit? You don't pro rate in
22 any way?

1 MS. NEWPORT: It's a real issue. It used to be
2 that we would have very, very few people that would get to
3 their pharmacy cap so there was a slight advantage over the
4 course of the year for people who enrolled later, in a way,
5 because they're not going to get to the cap. But the caps
6 are sort of stable annually. Now I think it is getting to
7 be an issue that is more awkward to handle and it's a
8 legitimate question. But I think our ability to flex in
9 some areas -- sometimes it's different from county to county
10 -- is really hard to explain.

11 So it's the right question and it's changed. I
12 think it's becoming more awkward, but I don't have any more
13 defined analysis than that.

14 DR. LONG: Just a data question. Do we know what
15 the disenrollees disenrolled to? Do we know the mix between
16 those who went to other plans versus those who returned to
17 traditional Medicare, and what kinds of cross-sectional --
18 if we have that data, how would that look cross-sectionally?

19 MS. GOLDBERG: It's in the dataset that we have,
20 and I've sent specs for them to do that analysis, but I
21 didn't have them for the meeting yet. But they're already
22 in S-Cube's hands and I'm waiting for them to do it.

1 DR. LONG: Without knowing what that would show,
2 what implications would you tend to draw from that if we saw
3 that a vast majority of any particular category went back to
4 traditional as opposed to went to some other plan? What
5 would that be telling us, do you think?

6 MS. GOLDBERG: From another study that the
7 inspector general had done, they found that people were -- I
8 don't remember what the percentage was, but a reasonably
9 large percentage were leaving their plan, going to get
10 inpatient care and then coming back to managed care. The
11 OIG estimated that that was about \$200 million that would
12 have been saved had those people remained in their managed
13 care plan rather than moving back.

14 DR. LONG: Saved by the trust fund.

15 MS. NEWPORT: We need to look at that more closely
16 because they didn't distinguish between voluntary and
17 involuntary disenrollments. They looked at only six plans.
18 There's a lot more depth and analysis that would need to be
19 undertaken so that that's really a well-grounded study.
20 There's lots of other studies out there that I think should
21 be used to flavor that part of the discussion that may be
22 more informative in terms of what you're really seeing

1 happening.

2 DR. NEWHOUSE: Hugh, what inference would you
3 draw?

4 DR. LONG: The question I'm raising is, if we saw
5 some sort of significant numbers here that we thought were
6 going to be affected by the new rules would we be more or
7 less worried about that if we saw that the majority of
8 people were simply switching plans?

9 DR. NEWHOUSE: I'm not sure I know the answer.

10 DR. LONG: I'm not sure I do either.

11 DR. NEWHOUSE: I think we ought to know how we
12 would answer that question before we push the staff too hard
13 to get the number.

14 DR. LONG: If we view this ability, the current
15 ability to disenroll as a market check on plans, it seems to
16 me that we might be more concerned then if it is a bailout
17 to traditional Medicare.

18 DR. NEWHOUSE: More concerned if I switch to
19 another plan?

20 DR. LONG: If we're going to limit that. If we're
21 going to say you cannot --

22 DR. NEWHOUSE: We're going to limit the switching

1 now. You can't switch to either in the new world. I'm not
2 sure what you switch to tells us much about the reasons for
3 switching or cause to be concern.

4 DR. LONG: Right.

5 DR. NEWHOUSE: I mean, you might have switched to
6 another plan to keep some drug benefits, or you might have
7 switched to traditional Medicare because you wanted more
8 access to specialists. I could invent stories either way.

9 MR. MacBAIN: Just to get back to the point that
10 Janet made because I don't want that to get lost, and that
11 is, if you're look at the numbers here it looks like about
12 half of the voluntary disenrollments will be affected, about
13 nine of the 18 percent. But the concern is, how many of
14 those that we're counting as voluntary disenrollments really
15 are not voluntary but are precipitated by a change in either
16 Medicaid eligibility, or employer's retiree health benefits?

17 If there's some way at getting at that, because
18 those folks are going to have a problem, and those are the
19 ones who are being treated as voluntary disenrollments but
20 really aren't. I mean, the voluntary is it's a decision
21 people make, and if they can only make it at one time of the
22 year rather than all of the year, it just puts them back

1 where they were as employees. So that's not such an
2 uncommon situation.

3 Do you know, is there any way we can get at that
4 information, how many of these really are not voluntary
5 because of something else going on?

6 MS. GOLDBERG: Not with the databases that I have
7 so far. If you know of any other ones that I might be able
8 to merge in...

9 MS. NEWPORT: There's a disenrollment survey that
10 the plans are engaged in or doing and I'm going absolutely
11 blank on -- some companies have been doing them all along.
12 Now it's mandated, and I don't know when all of that's
13 coming out. So there is material almost there.

14 MS. GOLDBERG: There's survey data that should be
15 available in 2001. But in terms of what's there right now,
16 I don't know of anything. There might be something I don't
17 know about.

18 MS. NEWPORT: It may be worth talking to some of
19 the plans because we want to know absolutely why people are
20 disenrolling. A lot of the times we know immediately
21 because we've changed a benefit, then we can track to
22 provider changes, and then there's the others. We don't

1 have an ability then to track necessarily if they've gone to
2 another plan. We know when some of those come into or
3 enrolled with us from another plan, but we don't necessarily
4 know the other way.

5 DR. WILENSKY: But I think this question, there's
6 been longstanding interest as to why people disenroll.
7 That's one issue, why people -- in a future world it will be
8 why people choose the plans they choose. That's different
9 from, it seems to me, trying to look at who might be
10 impacted when we go to annual enrollment. Some people, to
11 the extent that they can anticipate change, may choose not
12 to go in if they think they may want to leave.

13 To the extent that there has been a lot of people
14 who plan switch when they run out the drug benefit, join a
15 new plan so they can start the clock back. That's a
16 different kind of gaming of current attributes that -- it's
17 true, those people would be affected. I'm not sure when you
18 have the number, what you've learned by it.

19 I'm sorry, I was out. I don't know whether the
20 sense of -- whether there is enough here to warrant further
21 analysis.

22 DR. ROWE: Isn't one of the questions always that

1 we've got more to do than we have time?

2 DR. WILENSKY: And I was not overwhelmed that this
3 seemed like a high priority.

4 DR. ROWE: And now we've got even more of that
5 possibly coming?

6 DR. WILENSKY: Right, more to come.

7 DR. ROWE: There's got to be some point at which
8 while there may be some inherent scholarly interest --

9 DR. WILENSKY: Right, intellectual interest.

10 DR. ROWE: -- it's not the right allocation of our
11 limited resources.

12 DR. WILENSKY: That is certainly my sense. Again,
13 I apologize, I didn't hear the gist of what happened
14 although I tried to get a sense from Joe. I would think
15 does not -- I mean, this was fine. It was interesting. But
16 I don't see this as a high priority for future research,
17 given all that we have to do for our upcoming rounds of
18 reports and new mandated studies put on us. So I would
19 think maybe not pursuing this issue further than what we
20 already have seems appropriate. Are commissioners
21 comfortable with that?

22 DR. ROWE: I think the rationale is not that we

1 ignored it. We did the study. There are some data,
2 preliminary, but it's not very striking and nothing is
3 popping.

4 DR. WILENSKY: So we're going to not pursue it
5 further.

6 DR. BRAUN: It's not informative.

7 DR. ROWE: And it doesn't look like there's a
8 terrible problem in terms of access.

9 DR. KEMPER: I don't think we can tell that.

10 DR. WILENSKY: But I don't think we're going to
11 tell them doing the next round either.

12 DR. NEWHOUSE: That's right.

13 DR. WILENSKY: All right, should we go on to the
14 next session on the cost analysis?

15 DR. HARRISON: At the October meeting we discussed
16 the relationship of Medicare fee-for-service costs in a
17 county to the costs that Medicare+Choice plans would face in
18 the county, and we hypothesized that the plans' costs might
19 be less variable across counties than fee-for-service costs.
20 And we further hypothesized that Medicare+Choice costs would
21 not be as low as fee-for-service costs in low fee-for-
22 service cost counties, and would not be as high as fee-for-

1 service in high fee-for-service cost counties. Chart one
2 shows what the hypothesis was.

3 This past month I've begun empirically testing the
4 relationship between Medicare fee-for-service spending in a
5 county with the cost borne by the Medicare+Choice plans in
6 that county. To do this we obtained the adjusted community
7 rate proposals, ACRPs. These were submitted to HCFA in July
8 1999 for the year 2000.

9 For the first time these included plan base year
10 cost data. These are self-reported costs that the plans
11 incurred in providing the basic Medicare benefits to
12 Medicare enrollees in the 1998 base year. These submissions
13 are subject to audit with an expectation that a third of
14 them will be audited this year. So I think we have some
15 confidence that the plans took them seriously.

16 The fee-for-service county cost data came from the
17 1997 AAPCCs for the aged beneficiaries. And of course, the
18 AAPCCs are actually based on the average relative per capita
19 fee-for-service spending for the years 1991 through '95,
20 updated to '97. Then we further updated them to 1998 with a
21 national inflation factor since that data is not being
22 collected any more.

1 We also looked at the county level PIP-DCG risk
2 measure and input price adjusters from the HCFA rate book as
3 control variables.

4 The ACRP data contained 723 separate cost proposal
5 submissions by 251 different Medicare+Choice contractors
6 that included 1998 base year data. Each proposal is a
7 submission for the pricing of a specific product to be
8 offered in the year 2000.

9 Unfortunately, all but 181 of these proposals,
10 from 83 different contractors, are for multi-county areas.
11 This is probably because so many plans don't bother or are
12 unable to separate cost by county. It's also possible that
13 many plans don't think of adjacent counties as having
14 different costs.

15 While the data may be good, they're not very
16 appropriate for our purposes because we're trying to see how
17 the costs relate to the fee-for-service spending in specific
18 counties. We did do analysis on all of the submissions but
19 we're going to present the results from the analysis of
20 those submissions that were for an individual county.

21 We also limited the analysis to those cost data
22 that were based on at least an average of 1,000 Medicare

1 enrollees during 1998. This allowed us some confidence that
2 the average costs reported were based on significant
3 experience, and this further cut down the primary analysis
4 sample to 126 cost proposals representing 61 different
5 contracts in 79 different counties. We then aggregated the
6 data by county, averaging the cost experience of plans in
7 proportion to the number of enrollees in the county that
8 they had.

9 We would also have preferred to use plan-level
10 risk factors in the analysis but they were not available
11 yet, so we used the county-level risk factors from the HCFA
12 rate book. It turned out that that wasn't a very good idea.

13 One other thing to keep in mind about the data is
14 that we have data only from plans who submitted proposals
15 for the year 2000. Meaning they haven't pulled out of the
16 Medicare+Choice program in fact and that they were in to
17 start with in '98. The full range of possible values were
18 not represented. The minimum reported cost in this sample
19 was \$292 per member per month, and the lowest AAPCC
20 represented in the data was \$353. This really isn't
21 surprising since you'd only expect to find plans in areas
22 where they thought they could make a profit. Thus, the

1 really low AAPCC counties do not appear in the data.

2 We ran models with single county data only, with
3 single and multi-county data, with data aggregated at the
4 county level, unaggregated, log, linear, weighted,
5 unweighted, all kinds of combinations. While the
6 coefficients in the explanatory power of the models varied,
7 there were some consistent results. As illustrated in chart
8 two, the general shape of the cost function in chart one was
9 supported by all of the models.

10 Chart two shows a graph of one of the simplest
11 regression results. This model uses only the single county
12 submission data and aggregates those data to the county
13 level. The model is linear, and 79 counties that are
14 represented are unweighted. The r-squared for the equation
15 is .35 and the resulting formula is that the plan cost would
16 equal about \$120 plus about two-thirds of the AAPCC.

17 This particular formulation did have better fit
18 than some of the other formulations, but the relationship
19 between the plan cost and the AAPCC was very typical of all
20 of them. The coefficient on the AAPCC never got above .7.

21 DR. ROWE: Did I hear you imply that the portion
22 of the variance that was attributable to risk was 10 percent

1 of the variance?

2 DR. HARRISON: No, the r-square was .35.

3 DR. ROWE: Oh, the r-square. I thought you said
4 the r value was .35. So 35 percent variance.

5 DR. HARRISON: Right, which still may not be all
6 that high. I mean, there's still a lot of unexplained
7 variance there for sure.

8 We also ran a model substituting the payment rates
9 that would result from full implementation of the blend for
10 the AAPCC. So in other words, instead of using the AAPCC in
11 the equation we used the fully blended rate, and my two-
12 dimensional mind can't figure out a way to get it on a graph
13 so, I'm sorry, you don't have something to compare it with.

14 The explanatory was not always as high, but the
15 coefficient on the blended payment was consistently high and
16 varied from .8 to 1.1. This result suggests that plan costs
17 tend to track closer to the blended rates than to the fee-
18 for-service cost. But again, there's still a lot of
19 unexplained variance.

20 The continued move to blended payment rates may
21 help increase the number of Medicare beneficiaries who will
22 have a plan available to them. If we look at the fully

1 blended rates and compare them to the rates that the county
2 would be paid in the year 2000, we see that the median
3 beneficiary who did not have a plan available in their
4 county in '99 would have their county rate raised by 1.5
5 percent of the blend.

6 At the same time, the median beneficiary in a
7 county with a plan available would see the county payment
8 rate decrease by almost 2 percent. Since the cost model in
9 the previous chart suggests that the plan costs are
10 substantially lower than fee-for-service in the highest
11 payment counties, it is possible that the higher payments in
12 the low counties could attract plan entry, while the lower
13 rates in the high-rate counties might not cause plans to
14 exit, but instead they may be able to survive by lowering
15 the benefit package back towards the fee-for-service
16 package. Of course, this scenario is very speculative.

17 In order to make predictions of this sort we would
18 need to do more work on the model. We should properly
19 include risk adjustment factors. We should also expand the
20 model to integrate the enrollment decision process of
21 beneficiaries. As we learn more about plan cost and
22 beneficiary willingness to enroll in Medicare+Choice plans

1 we may find that payment modifications can improve the
2 ability to meet Congress' competing goals of low cost or
3 more choice.

4 For example, as speculated above, we may find that
5 shifting payment from an area where Medicare+Choice costs
6 are well under the fee-for-service costs to areas where
7 Medicare+Choice costs are just slightly under or maybe even
8 a little bit above fee-for-service costs, that might
9 increase the overall Medicare+Choice enrollment without any
10 net cost to the program. Or on the other hand, we may
11 discover that unless plans are able to deliver a threshold
12 amount of extra benefits, beneficiaries will not enroll.

13 Now I'd like to turn it over to you for
14 discussion.

15 DR. NEWHOUSE: Scott, I think I have a problem
16 with this, too. The inference I think you're trying to make
17 is that you want to pay each plan a fixed cost that's equal
18 to the intercept on this graph, or some other analogous
19 graph, and that you want to pay a variable cost that depends
20 on the slope of the graph. Is that right?

21 DR. HARRISON: That would be one possibility
22 perhaps, but we don't know that that would be a good

1 solution. But perhaps that could be one.

2 DR. NEWHOUSE: If that's not where this is headed,
3 then say where it is headed.

4 DR. HARRISON: The idea is to be able to build the
5 modeling capability to see whether that indeed is a good
6 choice or not.

7 DR. NEWHOUSE: That's what I thought. So the idea
8 -- and while the notion of fixed cost is intuitively
9 appealing, my problem is that I have another story that can
10 equally well explain this finding, which is that it's a
11 statistical artifact out of errors in measuring cost, either
12 from the ones you bring up -- you don't have the plan level
13 data -- or just that plans gear their costs to some long run
14 measure of their needs but there's year to year instability
15 in the AAPCC, even in the big areas where the plans are.

16 So random errors in variables would bias the slope
17 down and give you a positive intercept that you would wind
18 up potentially interpreting as fixed cost. At a minimum,
19 any errors in the variables is going to increase the
20 intercept and decrease the slope.

21 I don't see how -- I could think of ways to
22 potentially correct for the year to year variation to get

1 more of a permanent measure of cost, but I don't know what
2 to do about -- since I don't see how to quantify the error
3 variance from your other measures. I mean, the fact that
4 you're trying to map fee-for-service numbers into plan
5 numbers, or what the size of the errors would be there.

6 MS. ROSENBLATT: I guess I also have a concern,
7 but I'm going to come at it from a slightly different angle.
8 If I understood what you said, and I didn't pick that up in
9 reading the chapter, but from what you just said you have
10 almost no data on actual plan costs or what's reported --

11 DR. HARRISON: On this particular graph, right.
12 The other ones, there are a lot more data points on some of
13 the other measures, but --

14 MS. ROSENBLATT: I guess my question is, are there
15 really data points below the intercept, or is that an
16 extension of the line?

17 DR. HARRISON: No, there are not.

18 MS. ROSENBLATT: So it's even possible that what
19 we're dealing with are like two curves and you don't have
20 information about what the curve looks like below the
21 intercept.

22 DR. HARRISON: That's right.

1 MS. ROSENBLATT: And with a 35 percent -- we're
2 really guessing. That's one comment.

3 Two is, in real simplistic terms, if that is in
4 fact what one would conclude then there would be -- the only
5 reasons for the plan cost to be higher than fee-for-service,
6 one is more utilization, two is higher prices, and three is
7 a higher risk population. Now you did talk about the risk
8 population, but my guess is that if that in fact is real --
9 and my first question is, is it real -- is that it's very
10 possible that it's just providers are being paid amounts
11 that are higher than the Medicare payments by the plans.

12 DR. WILENSKY: Your response?

13 DR. HARRISON: Why would you think the plans are
14 paying more than --

15 MS. ROSENBLATT: If the plans are going to go into
16 those areas, they may find that the only way they can create
17 a plan in that area is to have some kind of fee schedule for
18 physicians that's more than 100 percent of RVS, just to use
19 an example.

20 MR. MacBAIN: Scott, does your Medicare+Choice
21 cost line represent cost for Medicare benefits only or is
22 that for all benefits?

1 DR. HARRISON: Medicare benefits only.

2 MR. MacBAIN: Does it include marketing and
3 administrative costs or again is it just the medical
4 benefit?

5 DR. HARRISON: It includes administrative costs.

6 MR. MacBAIN: Which is a constant. So that by
7 itself would kind of give you what you've got here.

8 DR. HARRISON: Right. I did it also for medical
9 costs only and got a similar shape.

10 MR. MacBAIN: But it just pushes the curve up a
11 bit.

12 DR. HARRISON: It just pushes it up a little more,
13 yes.

14 MR. MacBAIN: Did I understand that you were
15 telling Alice is that there are no data points to the left
16 of the intercept?

17 DR. HARRISON: Correct.

18 MS. ROSENBLATT: The intersection.

19 MR. MacBAIN: Right. Which suggests that health
20 plans are acting rationally if we treat the fee-for-service
21 line as a proxy for revenue.

22 DR. HARRISON: Certainly.

1 MR. MacBAIN: Which is what you'd expect. If
2 that's true and if there are no data points to the left of
3 that intersection, then does it really tell us anything that
4 we didn't already know?

5 DR. NEWHOUSE: Data points to the left would be
6 negative AAPCC.

7 MR. MacBAIN: No, to the left of the intersection
8 means that they're subsidizing it. They're taking a loss or
9 they're subsidizing it. I think your point is that the
10 blend will bring up payments in low-payment counties.

11 DR. HARRISON: Right.

12 MR. MacBAIN: Which we already know.

13 DR. HARRISON: Right.

14 MR. MacBAIN: And if it costs more a plan more to
15 operate in a low-payment county than they receive in revenue
16 under the current system, then to the extent the blend
17 brings up the payments it will make it more likely that
18 plans will operate in those counties, again which we already
19 know. So I'm not sure we gain a whole lot from this. Maybe
20 there's more in some of the other graphs, but as I read
21 through this I wasn't sure that it was telling us a lot we
22 didn't already know.

1 MS. NEWPORT: It told me what I already know, I
2 think.

3 Just a couple things. If this doesn't fall into
4 Jack's basket of things that we might not want to do right
5 now or may not be informative...

6 A couple of things. HCFA will not be doing a
7 third of the ACR audits this year. They're just right now
8 in their pilot stage, and I think that somewhere less than
9 15 plans have even been subject to a pilot error, and even
10 for my company it's one county. We filed over 139 ACRs this
11 last year. I'm wondering why now, but that's okay.
12 Paperwork reduction is having a whole new meaning for me.

13 At any rate, I think that we're still in a very
14 early stage and given that there is a notation here you
15 might consider putting something in the March report, I'm
16 not sure we'll have much to put in the March report on this.
17 And I think that one of the issues that we allude to is the
18 inability to do some system changes.

19 Also there are artifacts on state financial
20 reporting that doesn't -- it in the past didn't -- there's
21 no incentive to do anything on a county level basis for
22 financial reporting. So there's gap accounting and there's

1 ACR accounting and there's assumptions that you have to make
2 to bridge the gap. I think that there's a lot of
3 variability here and it's going to take a while for anything
4 meaningful to be out there to measure. But this doesn't
5 surprise me at all.

6 DR. KEMPER: First, I had a question just to
7 clarify. Am I correct in that there aren't observations
8 with less than about \$350?

9 DR. HARRISON: AAPCC, Correct.

10 DR. KEMPER: So basically this doesn't exactly
11 support your model in the sense that basically what you're
12 saying is, in the relevant range the risk plans, the
13 Medicare+Choice plans always have lower costs, it's just a
14 growing lower cost depending on how high the fee-for-service
15 costs are.

16 I guess I have a concern about an implicit
17 assumption here that I hope you'll make it explicit. And
18 then once you make it explicit I'll disagree with it.

19 [Laughter.]

20 DR. KEMPER: That is that the savings from moving
21 into managed care ought to go to the taxpayer rather than
22 the beneficiary. At least I read that that's an implicit

1 assumption here. That you want to find out what the cost of
2 delivery is --

3 DR. WILENSKY: I'm with you, Peter.

4 DR. KEMPER: You read it the same way?

5 DR. WILENSKY: And I agree with you.

6 DR. KEMPER: To me it does seem that isn't
7 consistent with what's been done in the past, and personally
8 it doesn't make sense to me. In the past we've assumed that
9 beneficiaries get the savings in the form of higher
10 benefits. It seems to me that's consistent with the equity
11 principle from the program that beneficiaries get the same
12 thing and they just get to spend it, if you will, in a
13 different form.

14 In addition, it seems to me that it's probably
15 necessary to attract beneficiaries into the Medicare+Choice
16 program. That is, just as in the commercial sector, in the
17 employed sector, people choose HMOs, at least in some cases,
18 because they have lower out-of-pocket costs, but in exchange
19 for that they have greater restrictions on their insurance.
20 And the same thing seems to be true in Medicare.

21 So that implicit assumption bothers me that we'll
22 just drive the payment rate down to the level of the cost of

1 the plans. I don't know whether that -- if this isn't going
2 a lot further, that's another question. The same issue will
3 come up in the update, so it's not like the issue is going
4 to go away. It seems a very important one to us.

5 DR. WILENSKY: That is an issue we can take up
6 under a variety of venues, is whether or not the
7 Government's payments ought to be similar, given risk
8 adjustment, irrespective of the plan or whether or not the
9 Government ought to take off part of the savings or all of
10 the savings is an issue that we can discuss I think at any
11 point we want to, either as an update or as a philosophical
12 issue or whatever.

13 DR. KEMPER: But it shouldn't be buried in --

14 DR. WILENSKY: Certainly not.

15 DR. HARRISON: That wasn't my assumption. My
16 assumption was that there were two competing goals. One is
17 to offer choice and the other is to contain costs. And if
18 you're going to expand choice you've got to find a way to
19 keep the cost down and maybe change where the cost -- who
20 bears the cost in which counties.

21 DR. WILENSKY: But this is only containing cost
22 for one sector. My comment would be is, you want to go

1 contain cost, decide how much you want to spend or how you
2 want to do it, but you should contain cost in one sector
3 versus another, personally. But again, I think we can have
4 the discussion at any point the Commission chooses to about
5 if there are different ways of providing care that have
6 different costs aside from the health status of the
7 population who ought to gain from the difference, the
8 Government or the senior?

9 DR. ROWE: Why do you feel that, Gail? It seems
10 to me --

11 DR. WILENSKY: No, I said we can have it if we
12 choose.

13 DR. ROWE: We're the wrong committee. The
14 committee is like the Ways and Means Committee or the Senate
15 Finance Committee to have that discussion. Really if the
16 goal is to get the money back to the taxpayer, we'll just
17 trash the benefits and close the program. Think of all the
18 money that would go back to the taxpayer. That's not really
19 MedPAC's concern.

20 DR. WILENSKY: No, I was saying -- it was only the
21 point, if the commissioners chose to try to raise that
22 issue, they don't have to worry about having a venue we can

1 bring it up in. I agree, I think that's -- we can raise it
2 but this is a question that the Congress would have to
3 answer at some point as it chooses to reform Medicare. It's
4 basically a philosophical issue.

5 DR. KEMPER: My only point, Jack, was that that
6 philosophical issue was buried in --

7 DR. ROWE: No, I understand that. I think we all
8 agree it was either not intended to be, or if so, it isn't
9 intended to be any more.

10 DR. WILENSKY: Let me go back though to the bigger
11 question that was raised. I hate to feel that we're picking
12 on Scott today. I've just been looking over his flipping of
13 pages at the legislative language potentially of what we are
14 going to, as MedPAC, be asked to deliver to the Congress
15 either, some of it in December of 2000. Occasionally for
16 one comprehensive study of all of the burdens of Medicare we
17 are actually granted two years, December 2000.

18 MS. NEWPORT: But for that one shouldn't we engage
19 in maybe a legislative policy of a MedPAC relief bill or
20 something like that?

21 [Laughter.]

22 DR. WILENSKY: It strikes me, looking at some of

1 these quickly, that we have some very significant research
2 issues to consider, even if we aren't able to do them all,
3 and that you have some considerable research skills that you
4 can bring to it. I would think rather than trying to push
5 this further, it looks to me like we'll have no problem
6 finding all kinds of areas to try to interest you in the
7 next 12 months. So again, I would think that there are just
8 much more important areas to pursue. If commissioners would
9 disagree or would like to --

10 DR. ROWE: We'd like to thank you for successfully
11 completing this analysis.

12 [Laughter.]

13 DR. WILENSKY: Thank you.

14 Beth, I think all the members of the panel are
15 here.

16 MS. DOCTEUR: MedPAC routinely considers the
17 implications of Medicare policy changes for beneficiaries
18 who reside in rural areas and for the providers who serve
19 them. We thought today would be a good opportunity to give
20 the Commission an opportunity to have a focused discussion
21 of some key world Medicare policy issues right now. We've
22 very fortunate to have a distinguished panel of expert

1 researchers to provide some food for the Commission's
2 thought.

3 Our first panelist will be Dr. Gary Hart of the
4 Washington, Wyoming, Alaska, Montana, and Idaho Rural Health
5 Research Center. He'll begin by giving us an overview of
6 what's important about rural areas and what we mean by rural
7 areas, what we're thinking about, and why it's important to
8 think about, what characteristics are important to think
9 about in terms of Medicare policy.

10 Our second speaker will be Dr. Keith Mueller of
11 the Rural Policy Research Institute who will focus on some
12 of the individual aspects of the BBA that have had
13 implications for rural hospitals, and also what we're
14 concerned about in terms of the combined effects of those
15 changes.

16 Our final speaker will be Dr. Ira Moscovice from
17 the University of Minnesota Rural Health Research Center.
18 He's going to tell us about how health care is organized in
19 rural areas and some of the implications of some of the
20 network development that's gone on in terms of
21 Medicare+Choice.

22 DR. WILENSKY: Welcome to all of you. Please

1 proceed.

2 DR. HART: Thank you. I'm going to try to do this
3 in 10 minutes. I've never done anything in my life in 10
4 minutes, but we'll give it a shot.

5 Let me speak a little bit about rural definitions.
6 I'm going to give a little bit of an overview and speak a
7 little bit to a study that we did that talks about where
8 people receive care. I'm on number one of this packet that
9 you have. The numbers are on the left-hand corner on these
10 overheads that I'm showing you.

11 The definitions of rural are very important to the
12 policy debate. They add to the context, a lot of the
13 statistics that you see, and often times you see things that
14 are contradictory and that's because people are using
15 different definitions. A whole slew, 37 or more, somewhere
16 over 40 programs now use various definitions to fund things,
17 to add bonus payments for Medicare, various sorts of things.
18 Rural is really a multidimensional concept and there's a lot
19 of aspects to it. Sort of like love, we all think we know
20 what it is and there's a million definitions, but we all
21 know how the divorce rate is extremely high.

22 [Laughter.]

1 DR. HART: Many of the definitions -- I listed a
2 bunch of them here. The two most important ones that get
3 used a lot are the Census Bureau's definition, the rural and
4 urban definition, and a non-metropolitan, metropolitan
5 definition by the Office of Management and Budget. Those
6 two definitions, one census tract based, the other is county
7 based, you see those numbers all the time. Fifty million
8 people fall into the category of being opposite classed.
9 They're rural in one and urban in the other, or vice versa.
10 Fifty million people fall in that class. That's how
11 different they are.

12 There's a whole other series; the ad department
13 has developed a bunch of definitions. Down toward the
14 bottom, the rural-urban commuting codes are some areas, are
15 ones that we just developed that use census tracts. For
16 instance, they were just used in, are being used in the
17 legislation related to metropolitan areas and carving off
18 the rural parts of those and making available so hospitals
19 can become CHs.

20 Moving to the next overhead, which actually you
21 don't have a copy of this one. The reason I put this up
22 here is just to remind myself to talk about how important

1 the definition is when you're talking about it. Saying
2 rural doesn't mean anything unless you get specific about
3 whether you mean big rural, little rural, remote rural, what
4 do you mean?

5 Speak a little to the rural environment. It's
6 consequential. There are 60 million rural people. That's
7 more people than are in Great Britain or France. It's a lot
8 of folks out there in rural areas. Nine million of those
9 are elderly, 65 and older, and that's the population of
10 Cuba. Rural folks are generally poorer, less educated. The
11 population growth, although we think of those places as
12 shrinking, they aren't shrinking. They've actually grown in
13 the last 20 years. Some places, specific places have got
14 smaller, but they're growing.

15 DR. NEWHOUSE: Is that on both the leading two
16 definitions?

17 DR. HART: Yes, by any of these definitions. Some
18 of them creep, like OMB's definition keeps designating new
19 places so it's hard to look at that, but it has grown.
20 Farming doesn't equal rural. Less than 3 percent of the
21 population is in farming. When you think of rural you
22 usually think of haystacks, and that isn't what most of

1 rural is.

2 There's higher unemployment and higher
3 underemployment. When the economy turns down, rural areas
4 do worse. They tend to be more specialized economically so
5 they're impacted more when specific sectors of the economy
6 go down.

7 Then finally, all of the above are not true for
8 anywhere, because there's such diversity. No place is like
9 what I just described.

10 How is rural different? It's diverse. There's
11 rich and poor. There's places of 40,000 people and there's
12 places of 40 people. They're close to urban and far from
13 urban areas, and places where there's no roads. I'm just
14 trying to -- it's a great, incredible diversity. Mining,
15 agriculture, tool manufacturing. There's ugly places and
16 beautiful places.

17 What I'm trying to get at is, it is the entire
18 spectrum. You all have gone on vacations or come from there
19 or lived there, but it's dramatically different from place
20 to place. Some places are all white, some are all African-
21 American. There's all, every mix in between. So great
22 diversity.

1 Secondly, vulnerable and fragile. Many places are
2 very small. A town that's got two docs, if one of the docs
3 leaves they've lost half their health care force. If
4 they've got one hospital in a region and it's small, with 30
5 beds, it's very fragile to things. We'll speak more to
6 that, I'm sure.

7 There's low density, small populations, and places
8 are remote. Low volume and relatively high fixed costs
9 makes the per unit of providing services more expensive
10 often in these places. There may be differences in cost of
11 living, but there's differences, the real cost of supplying
12 the services because of the high fixed costs.

13 Long distances, which means somebody has to pay.
14 The beneficiary who has to drive, behavior changes, people
15 delay receiving care because sort of the friction of
16 distance, the cost of going somewhere is higher for them.
17 So there's more differences.

18 There's fewer health care providers and
19 facilities. There's an emphasis on generalist providers
20 instead of specialists, so there's a much higher percentage
21 of generalists in those places. There's relatively little
22 physician training and other kind of training taking place

1 in rural areas and funding of that.

2 There's a significant gender mix difference.

3 There aren't as many female providers of any kind,
4 especially of physicians. Every year more and more
5 physicians are females. That's the good news, they're
6 graduating more and more female physicians. The bad news
7 is, they're less likely to go to rural areas.

8 Privacy issues. Again, I don't have time to speak
9 about each of these. Quality assurance issues. There's
10 three docs in town, how do they deal with quality assurance
11 amongst them?

12 Next, number four, moving to the next page, just
13 the idea -- this is just to show you that if you're looking
14 at the different groups across time, these are the numbers
15 of physicians per 100,000 by the various kinds of geography.
16 The lowest one that I've shown here is the most rural. You
17 can get much more rural than that. Notice the line is
18 almost flat. And if you actually cut it out and did it for
19 places of 2,500 or less it would be flat. That is there's
20 been no real growth in the last 50 years.

21 The next -- actually you don't have it but it will
22 show up in the overslide. It was handed out separately

1 because it didn't get collated, but it's the map that's
2 loose.

3 All that map is showing that, depending where you
4 are in this country, if you're a female Medicare beneficiary
5 and you want to see a woman physician and you live in a
6 rural place, there are states where it's 11 to one male and
7 your odds of having access to a female physician are one-
8 sixth to one-tenth as much as in some other parts of the
9 country. The red places being the places, or the dark ones
10 on your copy, being the places where there's the highest
11 ratios like that in rural areas.

12 On to the next one, rural health status. Like me
13 just say in general -- I'll summarize this without going
14 through each point. Some things are worse for Medicare
15 beneficiaries: auto accidents, arthritis, heart disease,
16 those sorts of things are worse. Some things in rural areas
17 like HIV and AIDS and malignant neoplasms are actually
18 better in rural areas, and a lot of things are the same. If
19 you look at age, sex, race adjusted mortality rates in rural
20 places, they're the same as in urban places. There really
21 isn't a quantitative overall difference between the two.

22 Rural practice differences. Keith and Ira are

1 going to speak about the financing and practice
2 arrangements. Let me just speak about the first one,
3 clinical practice variations. There are very large
4 differences in how people practice.

5 We've done study after study at our center and
6 other studies showing that there's significant differences
7 in how physicians practice in rural areas. They tend to use
8 less resources. Family physicians, for instance, in rural
9 areas use -- they have a broader scope of practice, see more
10 things and do more procedures than their counterparts in
11 urban places.

12 The next one speaks to quality. Again, I'm not
13 going to go through each one of these. Be glad to speak
14 about them individually or provide information. It just
15 goes along and talks about several of the things one needs
16 to think of when one is looking at that. The drift is on
17 some things you find it's better care in rural places,
18 sometimes you find it's worse. There's not a lot of
19 evidence either way in general. You need to take that into
20 consideration given the resources and given the shortages
21 that are available in places when you look at it.

22 From our standpoint in WWAMI, we train physicians.

1 They get the same grades. They come from -- they get
2 through our school in the same kind of training programs.
3 Half of them go to rural places, half of them go to urban,
4 and we're having a hard time understanding why anybody would
5 think the ones that go to rural places are significantly
6 different in the kind of care they practice, other than
7 those things that are pressuring them one way or another.

8 Next one, what I'm going to end by speaking about
9 is a study that we're just completing. It will be available
10 in December. I'll give you the cover page and we'll make
11 sure that the staff receives copies and that you can see
12 them if you want. It uses Medicare Part B data to look at
13 where Medicare folks in Washington state go for their care.

14 The next page, nine, shows who the study folks
15 are. Then going on to 10, this is the population, 362,000
16 Medicare folks. It shows that 29 percent of those are rural
17 in Washington state, 14 percent of them live in remote kinds
18 of places. Remote meaning not by metropolitan areas, and
19 small meaning in service areas of hospitals of less than 100
20 beds.

21 Going to the next one. This summarizes the data
22 related to the resources of the folks that live in these

1 different places use. From large remote to small remote to
2 large adjacent, small adjacent, and urban. I think a couple
3 of points out of this diagram. Look at the bar about
4 outpatient physician visits for small remote. That's at
5 6.4. That's 20 percent less than urban. People who live in
6 small remote places get 20 percent less physician visits
7 than do folks that live in urban environments. Note that
8 the big rural places get just as many. If you look at the
9 other measures about hospital days and hospitalizations,
10 inpatient visits, there's no differences.

11 Turning to the next one, how are those visits
12 different? The rural folks in small remote -- I've just
13 taken out the small remote and urban, so I get the contrast
14 here for you. This next diagram, number 12, shows that they
15 actually have more family physician visits, less general
16 internist visits. But most of the difference is what's
17 going to follow in 13, 14, and 15 which you can look more at
18 your leisure.

19 What those diagrams show, looking at putting 13 up
20 right now, it shows that people in small remote places on
21 average every year -- this is how many average visits you
22 have with these specialties. And we haven't used Medicare

1 specialties. That tends to be -- they're not right. We've
2 hooked the AMA and the American Board of Medical Specialty
3 data in so we're getting the specialties right on physicians
4 they're seeing. There's a lot of error in assignment of
5 physicians in the database.

6 You can see they get about half as many visits to
7 every one of the medical specialties. You look at the next
8 one, they get less of most of the surgical specialties, but
9 it's less different. Then if you look at other specialties,
10 again they get less, half as many often times, average
11 visits a year to those specialties.

12 Then looking at number 16 is a diagram that looks
13 at market share. We've put all folks in the state into
14 markets. They're either the local market area around a
15 rural place or around an urban place, and then we've looked
16 to see where folks go.

17 This is how many rural people stay in rural
18 places. Not home, but in another rural place or go to an
19 urban place. So the 89 percent you see there says that 89
20 percent of the rural folks that live in remote places get --
21 89 percent of the visits that took place, took place in some
22 kind of rural place. Eleven percent took place in urban

1 places. You can see it's very high. The little adjacents
2 are almost bedroom communities, so that's much lower.

3 I don't want to speak at length to any of the
4 others. I'll just kind of overview them as I kind of flip
5 by here. In 17, all it shows is that Medicaid people are
6 more likely to stay home. The next one looks at age and
7 shows that the older Medicare folks are more likely to stay
8 in the local communities and stay in rural places, and the
9 younger ones, younger folks are more likely to go to urban
10 places.

11 The next one just looks at local instead of all
12 rural, and you can see there's not much of a drop. Most
13 people or almost -- most folks get their care locally from
14 Medicare in Washington in rural places.

15 The next one, one of the things you're thinking is
16 all the sick people who are really sick go to the urban
17 places and stuff to receive care. The next one shows that
18 that's not the case. They're pretty flat. That's number
19 20. Really it reviews the ACGs to control for severity and
20 look at the market shares for that. And what this shows,
21 there's a lot of rural folks really get their care in rural
22 places that are very severely ill.

1 The next one, 21, simply looks at an aspect of who
2 gets all of their care in a rural place. Three-quarters of
3 the people in three of those categories receive all their
4 Medicare care in one place. I've got a whole series of
5 others that I'll just not -- you can take a look at your own
6 -- is what percentage of that -- "p" is percentage of people
7 who get the majority of their care, percentage oncologists.

8 Then finally, 25. The idea of all those is that
9 most people get most of their care in rural places. Twenty-
10 five shows all the folks that had diabetes visits, 80
11 percent of them were in rural places, and really when you
12 look at it, who they went to when they went out. That's the
13 blue columns or the dark columns on yours. Those are the
14 folks who -- the visits that left town, left and went to an
15 urban place clearly fall into places like diabetes and
16 endocrinology where there are no rural physicians so they
17 have to go for care. But the large majority, again, of the
18 care goes there.

19 One last diagram before I summarize. Twenty-six,
20 think of this big rectangle as all the visits that took
21 place in Washington for rural people, even the ones in the
22 bedroom communities. Those visits, the dark part is what

1 took place locally. The white part is what took place in
2 urban areas, and that cross-hatched part is the part that
3 took place in other rural places. You can see that almost
4 all of the care took place -- and then each bar represents
5 all the towns in Washington, the service areas. So again it
6 looks about -- who -- where the majority of the care is
7 taking place.

8 Let me summarize on 27. It's a summary, the
9 Washington Medicare summary. The vast majority of care
10 received by Medicare folks in Washington state took place in
11 local or in other rural places. Very little went to urban
12 places. Few rural elderly have strong ties to urban
13 physicians. They don't have majority relationships with
14 them. The urban receive about 20 percent more than people
15 that live in small remote places. There's less specialists
16 and more generalist care. Many of the very ill receive care
17 within a rural area. Most urban trips are for care that's
18 unavailable in rural areas. And large rural places really
19 become the referral centers.

20 Then the question that I always try to ask about a
21 study is, so what, which is 28. It says, number one,
22 damaging a rural health care system that is much more self-

1 contained than most of us usually think about -- we usually
2 think of it as being an appendage to the urban system when
3 in fact it's almost self-contained, at least in Washington
4 state -- and commonly thought to have significant
5 consequences on the care system there.

6 Secondly, remote small town elderly receive a lot
7 less care, ambulatory physician visits, and this may
8 influence their health status. Is that good or is that bad?
9 Don't know. Doing some studies in fact. Looking at
10 diabetes, seeing if they get their guideline stuff as much
11 right now out of these same data. The drift is they get
12 less of the guidelines in the small rural remote places.

13 Other things like telehealth when we're building
14 and paying for things, if we create systems that bypass the
15 local referral centers into urban places it would be
16 dramatically affecting the system because that's not how the
17 system works now, and that is how we fund telehealth, tends
18 to go to big regional tertiary centers. Not regional, but
19 urban tertiary centers.

20 So then -- and finally, I've already mentioned
21 this, the question -- the major limitation here is, how much
22 is Washington like other places? I think it's very much

1 like most of the west. It's not clear, if one does this
2 detailed kind of analysis, what it looks like in Georgia.

3 Thank you.

4 DR. WILENSKY: Keith?

5 DR. MUELLER: Let's move on to the presentation,
6 Medicare payment to rural hospitals including the impact of
7 the BBA. When the title slide comes up, those of you
8 sitting behind me might want to write down at least one of
9 the web sites because you will be able to get these
10 overheads from that web site probably as soon as tomorrow.
11 Of course, you can't read this because it's too small. The
12 one on the left is rupri.org and you can get anything of
13 this off of that tomorrow, and it will link to the one on
14 the right.

15 I have the pleasure of presenting the presentation
16 with some details that will be out of date probably Friday
17 and maybe Monday, depending on how rapidly Congress votes
18 through the current omnibus appropriation bill because I'm
19 talking about impacts of the BBA. As I know you are aware,
20 many of those impacts are going to be altered, or at least
21 the provisions altered in the legislation being debated this
22 week.

1 Having said that as a major caveat, I think we
2 should still look at some of those provisions, and I will do
3 that this afternoon, and try to learn some lessons from
4 them, which is what I will be concluding with about how we
5 create payment categories that affect small, low volume
6 institutional providers and how we create payment categories
7 that might affect isolated providers, and coincidentally,
8 they are the same.

9 My numbers are in the bottom right corner, the
10 exact opposite of where Gary's were.

11 The impacts that I'll talk about, a special note
12 will be on small hospitals, those under 100 beds or those
13 under 50 beds. I often get asked, what does small mean?
14 And there's a lot of variation, as Gary talked about, it
15 carries a little different meaning depending on what state
16 you're in. In my state of Nebraska, under 50 is small; over
17 50 you're getting pretty big. In other states, the rural
18 hospitals, it's under 100. So that's why I tend to use both
19 categories and you'll see me slicing implications for under
20 50 and for under 100.

21 They are low volume providers. They're generally
22 not-for-profit hospitals. They're government-owned or

1 community-based not-for-profit nongovernment-owned
2 hospitals. They're essential providers in many of the
3 communities because of both the isolation and the hospital
4 provides an array of the services. This includes when you
5 look at under 100, under 50, over two-thirds of all of the
6 rural hospitals have fewer than 100 beds, 42 percent or 916,
7 fewer than 50.

8 The ownership breaks out as not-for-profit 47
9 percent approximately, government 44 percent, and for-profit
10 is a very minor player in rural areas at 9 percent, using
11 1997 data.

12 Inpatient margins generally were negative from
13 fiscal year '88 through FY '93, and have become somewhat
14 modest since that point. But margins are really only a
15 small part of the picture because they can disguise some
16 important variation within an aggregate number, so some
17 important lows as well as highs. And the inpatient view, as
18 some of your own documents have pointed out is rather
19 restrictive.

20 In 1997, outpatient revenue accounted for over 47
21 percent of the patient revenue for rural hospitals. In
22 1996, if you look to Medicare, it represented 60 percent of

1 the inpatient acute care days, so it's a major player for
2 rural hospitals. For rural hospitals under 50 beds it's 63
3 percent, and for those between 50 and 99, it's 58 percent of
4 all of the inpatient days for those hospitals.

5 In '97 then Medicare ends up accounting for over
6 47 percent of all revenues for rural hospitals. This means
7 any change in Medicare payment has an immediate impact on
8 hospitals, and the choices for relief of the impact, if
9 relief is warranted, are rather limited. Trying to find
10 those alternatives or choices in the area of efficiency is
11 difficult, and I'll get to that in a later argument. Either
12 low volume --

13 DR. WILENSKY: Keith, let me just interrupt a
14 minute. I really want you to share with us what you think
15 the most important issues are, but I want to plead with you
16 -- and I'm going to explain why -- that you don't spend our
17 time going through 29 or 30 overheads which are in our
18 packet. This is an opportunity for you to tell us the
19 issues you think are most important and share some of the
20 most important data, and to try to have a dialogue with the
21 15 commissioners here who will be in a position to try to
22 make recommendations. It's why we've asked you to try to

1 limit your presentations to 10 minutes.

2 So I'm just going to plead with you, please do not
3 go through 30 overheads, because there's no way anybody
4 speaking in English can go through 30 overheads in -- I
5 mean, we really want to hear what you have to say, but
6 please try to be selective.

7 DR. MUELLER: Fine. If you would then skip
8 through the overheads. Actually, what I am going to do is
9 not read from the overhead but I have notes about the points
10 I'm trying to make with the overhead. I appreciate your
11 comment, Gail, and it's well taken.

12 The point about Medicare as a major payer is, as I
13 was saying, the immediate impact and the limited options
14 rural hospitals and other rural providers have, for that
15 matter, to look elsewhere, either to efficiencies or to
16 other sources of payment. The non-profit hospitals and
17 government hospitals do tend to look to their other sources
18 of revenue.

19 So when you examine, for example, some of the
20 graphs that follow about the profit margins of rural
21 hospitals and you compare an operating margin to a total
22 margin, the reason those graphs are in there is to show you

1 that the operating margin is often times in the negative,
2 but if we look to the total margin it remains slightly
3 positive. That's the impact of community-based hospitals
4 deciding to use other sources of revenue, be they government
5 revenue from taxes, or private revenue from not-for-profit
6 foundations.

7 The hospitals in the rural areas are providing
8 multiple services, from inpatient to outpatient obviously
9 for hospitals, but also skilled nursing, home health. There
10 are numbers in another one of the figures that tell you what
11 percentages of hospitals offer which services. That's again
12 in part back to the philosophy of the community-based not-
13 for-profit hospital, that believes it's the available
14 provider in the community.

15 Let me just give you one -- I know it's anecdotal
16 and a lot of information we're getting right now is
17 anecdotal, but I think it's a telling case.

18 If a home health agency that's a not-for-profit
19 non-hospital based home health agency closes in a rural
20 community, often times the hospital feels an obligation to
21 open its own home health agency. For two reasons really.
22 One, another major point that's in the specific information,

1 is the hospital is trying to minimize length of stay and
2 inpatient days used. So the discharge to home health is
3 important. If the home health agency closes, the hospital
4 needs the option, opens a home health agency.

5 But also secondly, if a hospital doesn't do it,
6 with its capability of getting government revenue or
7 wherever else it might come from, there's no one else in the
8 rural community who would do that and continue to provide
9 that service.

10 One of the important points, and it's contained in
11 a series of slides that I actually did not intend to go
12 through in any detail but I want to make sure you had, and
13 that's the low volume issue for rural hospitals. What I've
14 done in the packet that I gave you today is go through the
15 historical recognition of the low volume issue, beginning in
16 1983.

17 And actually the first studies that came out are
18 '87, '88, a couple of studies that appeared in the Health
19 Care Financing Review that talk about when you examine what
20 the impact of Medicare prospective payment was, you do see a
21 distinctly different impact among low volume providers.
22 Then trace that acknowledgement through some of the

1 regulations you were talking about this morning in home
2 health, and you talked about previously in outpatient care
3 in which you again see acknowledgement even in the proposed
4 regulation, these will have different impacts in small rural
5 institutions because of low volume.

6 The low volume impact is not because the
7 institutions don't try to nevertheless control costs. It's
8 because -- the language gets a bit arcane, I admit, in the
9 '99 home health regulation. It's because economies of scale
10 operate differently in a low volume situation. A few
11 adverse cases can throw you wildly in a negative direction
12 and you don't have the volume it takes to offset those, and
13 you can't increase volume as rapidly as you might want to to
14 offset those.

15 Given the low volume situation, the impact this
16 might have then when you look at provisions of the Balanced
17 Budget Act. Now at this point in time -- and again, your
18 commission has been very helpful in reporting some of this
19 -- we don't have the exact hard data that we might want to
20 have, but we do have two sources of information. One source
21 is the sort of dually account debate about projections based
22 on cost report data and looking out into the future. Those

1 are the national reports that were commissioned to Ernst &
2 Young and to Lewin, and some of the data from those are in
3 here as well as some information from your papers and memos
4 about critiques of those.

5 On balance, the trend is not disputed, that indeed
6 the negative impact is higher in the low volume. There's a
7 question of degree of impact. Do the margins drop all the
8 way below zero or not? The direction though is obvious in
9 those. A second source comes from state reports, and I was
10 able to secure a few of those from Louisiana, from North
11 Dakota and a couple of other states that are also in your
12 information packet, that show the same thing at the state
13 level.

14 Now for the caveat that I started with. A lot of
15 that does include the effect of the outpatient PPS. As you
16 know, in the BBA refinement legislation there's a provision
17 to do away, in effect, the outpatient PPS for three years
18 for hospitals under 100 beds.

19 The point of the slides remains an important one
20 to consider -- actually two points. One, the effect is more
21 pronounced in the low volume rural providers. And secondly,
22 it comes as a result of the cumulative impact of a number of

1 the provisions. So it includes not just outpatient, but it
2 does include home health, both the IPS years as well as the
3 prospective payment years. It does include skilled nursing
4 that has already had an impact in rural hospitals because of
5 the provision that says if you opened it after '95 you're
6 immediately into the PPS system. It does include transfers,
7 does include other provisions from the BBA.

8 Where does that leave us? Go to the back end of
9 it. There are, from the documents that RUPRI has produced,
10 some suggested remedies. This is on page 28 -- some
11 suggested remedies, one of which is a direction we'd love to
12 see the Commission and its staff take. That is when we're
13 analyzing Medicare payment and payment changes, to be sure
14 we do that by category of hospital and that small rural,
15 whether you use the 50, 100, or both, cut point, is one of
16 the ways in which we look at that analysis.

17 It's a bit different than what we normally see.
18 We see small sometimes broken out. We do see rural or non-
19 metro broken out. We really need to break it out as small
20 rural in order to get at this issue of impacts, especially
21 as related to volume.

22 When we think about rural home health services we

1 need to watch carefully, and there's a quote in the
2 paperwork from Mathematica's evaluation of that. To look
3 carefully at isolated home health agencies, small isolated,
4 to make sure that we don't adversely affect those with a
5 prospective payment system. And we need to always be
6 examining, as you are today, the rural impact of any changes
7 in payment including PPS.

8 There are some changes, and I've talked about
9 those already, in the BBA refinement legislation that would
10 have an impact on this. I'd close with two further thoughts
11 that are not directly from the panel but from myself after
12 putting this together for you today.

13 One of those is that we might want to begin
14 examining payment categories that are based on size of the
15 institution and some measure of its dependency on payment
16 streams. There's some hints at that in some of the
17 documents in the slides that came out of Walsh Center
18 studies on that.

19 And we might look at allowances for exceptions to
20 payment policy as a function of size and volume when we look
21 at outliers and different exceptions to the payment.

22 DR. WILENSKY: Thank you. Ira?

1 DR. MOSCOVICE: Thank you for the opportunity to
2 speak today. I think I can get through these in 10 minutes.
3 Being last, I suspected that I'd have the least time.

4 We were going to talk about three things today.
5 The Commission asked me to first speak about where do
6 networks fit into the whole issue of risk sharing and
7 managed care in rural areas? Second point was, what do we
8 know about managed care enrollment in rural areas? We
9 translated that to HMO enrollment. Third part, what about
10 promoting choice for Medicare beneficiaries in rural areas?
11 I was asked, what can be done to try to promote that?

12 I think the most important question is, why are we
13 promoting choice in rural areas? And we'll talk a little
14 bit about that.

15 With respect to networks, we've been studying
16 rural health networks for a while. We need to understand
17 that the first and most important thing is we have to define
18 a network. When you say multi-hospital system, usually you
19 know what you're talking about. With respect to a network,
20 you don't. So we proposed a definition a while ago that
21 suggests a network is a formal organizational arrangement
22 amongst rural health care providers and others that use the

1 resource of more than one existing organization, and so
2 forth.

3 What it basically says is this can't be, let's go
4 down to the coffee shop and chit-chat. We're doing more
5 than just talking to each other, we actually have some
6 specific activities above and beyond lobbying that we're
7 going to be doing, and that it has to be formal. Not
8 incorporated. Could be a memorandum of understanding, a
9 written agreement though at least it suggests who's in the
10 organization and what the organization is about.

11 We've looked at trying to figure out where these
12 networks exist. By definition, we got at this through
13 saying, if a network existed that was central to the rural
14 health community, it had to have the rural hospital
15 involved. We backed into it by asking all rural hospitals
16 in the country are they involved in networks or not, and to
17 define those.

18 We looked at the information that's on the
19 overhead right now. We did this with support from the
20 Robert Wood Johnson Foundation in 1996, basically identified
21 180 rural health networks in the United States. A very high
22 response rate. Almost half of those were hospital-only

1 networks. And there was a lot of interest in these networks
2 from urban hospitals, as you might imagine. About 40
3 percent of the networks also had physicians in them.

4 So what's that saying is back a couple years ago
5 this still was a very hospital-dominated organization. But
6 there were more rural hospitals in networks at that point in
7 time than there were in multi-hospital systems. So it was
8 potentially viewed as a real strategic response to the
9 environment at that point.

10 If you look at the next overhead, when we asked
11 these networks what were their relationships in terms of
12 contracting with HMOs what we saw was overall a fifth of
13 them, one out of five said they had at least one contract
14 with an HMO. So the vast majority of these networks weren't
15 doing contracting with HMOs, and as you might expect, the
16 ones that had physicians had greater percentage of contracts
17 with HMOs.

18 So what we're concluding from this is that at that
19 point in time -- and we've started -- we're going back to
20 networks now at the beginning of the year 2000 to see how
21 these networks have matured and what new entries we have
22 into the market. We estimate there's about double the

1 number of networks at this point as there were then.

2 What we've seen though when we've gone out -- and
3 there are a lot of federal demonstration projects, state
4 demonstration projects, foundation demonstration projects,
5 both national and state foundations, and what we've seen is
6 that the networks we've visited are really primarily
7 interested in developing administrative service
8 organization, community health organization type functions:
9 the infrastructure for managed care. But they're really not
10 interested in taking on a lot of provider risk.

11 So at this point in time it's a transitional
12 phase. We're seeing that networks are starting to build up
13 some of that infrastructure, but the vast majority of the
14 networks that are out there now are really not involved with
15 risk-bearing arrangements for their providers.

16 Second part of the presentation deals with HMOs
17 and the enrollment of rural populations in HMOs. The first
18 thing to note is that if you look at the interstudy data,
19 the potential access to HMOs in rural areas has increased
20 substantially.

21 Almost every HMO says they have at least one rural
22 county in this service area. This is meaningless

1 information at this point in time because most of them are
2 not serving. They have included them in their service area
3 but what's really important is to look at actual enrollment.
4 Nearly all those HMOs, by the way, that serve rural counties
5 have their headquarters in urban areas. There are less than
6 a dozen rural-based HMOs. So what we're talking about when
7 we deal with managed care in rural areas are urban
8 organizations that are moving out to rural areas primarily.

9 When we look at the commercial side, they look at
10 this one of two ways. There are some studies that are
11 starting to look at the interstudy data and looking at
12 commercial enrollment out in rural areas. The reality of it
13 is, interstudy has had about half of the HMOs reporting data
14 by county level. They're going to be up to about two-thirds
15 hopefully next year, and pretty soon we're going to have
16 commercial level enrollment at the county level.

17 But right now we don't have that. So what we did
18 was called out to each of the states, whether it was the
19 insurance agency, department of health, whoever the
20 appropriate agency was. There are about 15 states that
21 actually report county level data right now. We have 12
22 states that we're going to show you information about in the

1 next couple of overheads, and we have a couple more that are
2 coming on board.

3 It ranges anywhere from 1.2 percent in Montana up
4 to about a quarter of the population in Wisconsin. Rural
5 HMO enrollment rates, as you might expect, are highest for
6 rural counties adjacent to large metropolitan areas. Urban
7 residents in the 12 states that report these data are 2.6
8 times as likely as rural residents to be enrolled in a
9 commercial HMO. That's as of year-end '98. When we did
10 this back in '96 it was three times. So the difference is
11 narrowing a little bit.

12 I just want to show you two maps that illustrate
13 that you can have -- despite the notion that you can build
14 managed care out in adjacent areas, states have had
15 different strategies. If you look at my home state of
16 Minnesota, in fact the darker areas there mean more managed
17 care penetration in rural areas, the white areas are the
18 urban areas. What you see in fact is that the managed care
19 penetration really is highest for the commercial population
20 in adjacent counties.

21 But if you look at the next overhead, the state of
22 Wisconsin, it's a very different strategy. There has been

1 an explicit strategy in that state amongst some of the large
2 system, whether it's Marshfield Clinic, whether it's the
3 Gunderson Clinic, the Mayo Health System in Minnesota that's
4 moving over, Aurora Health Care, a variety of entities that
5 are providing, that are serving rural enrollees via HMO
6 mechanism. It really is a statewide strategy. A quarter of
7 the rural population at this point in time is in HMOs.

8 So if we move to the next slide. You obviously
9 know the Medicare data better than I do, but the good news
10 is we've tripled the rate over the last three or four years.
11 The bad news is we're still at 2.5 percent. So it's not
12 really substantial in terms of Medicare risk plans. As
13 you're well aware also, at the beginning of this year a
14 quarter of rural Medicare beneficiaries were in risk plans,
15 were in HMOs that cancelled risk contracts, and a quarter of
16 that group also were in a county that had no other risk
17 plans available. We're going to see some more of that in
18 January in a couple months.

19 The new growth, as your staff I know have pointed
20 out, pretty much balances the reduction. So it's not quite,
21 but it's pretty much we're gaining as much as we're losing
22 at this point in time.

1 I just wanted to show you for the 12 states, this
2 is year-end '98 data. Really the data comes whenever the
3 states have it. It could be fiscal year. It usually is
4 anywhere in the last three months of the year.

5 What you see if you look at this is that comparing
6 commercial and Medicare enrollment rates for urban and
7 rural, if you look at the states that have a high commercial
8 rural rate such as Pennsylvania, New York, California,
9 Wisconsin. In Pennsylvania, once again, this is a Geisinger
10 effect, Keystone Health Plan effect. Once again, a very
11 high, 15 percent of the rural Medicare beneficiaries in that
12 state are in risk plans.

13 But you look at Wisconsin where I showed you a
14 quarter of the population, virtually none of the population
15 are in Medicare risk plans. A lot of that has to do with
16 the bad experience that Marshfield had, and that really has
17 permeated other health plans in that state in terms of the
18 low enrollment there.

19 There's not a one -- there's a stronger
20 relationship actually between the commercial enrollment and
21 the Medicaid enrollment in a state than there is between
22 commercial and Medicare.

1 Last slide on enrollment gets at the whole issue
2 of the Medicaid HMOs and prepaid health plans. This is not
3 primary care case management. This is straight HMO prepaid
4 health plan enrollment. That's gone up substantially from
5 10 percent in '95 up to a quarter of Medicaid beneficiaries
6 around the country in '98-'99 are in Medicaid HMOs. Most of
7 that's concentrated, a lot of it's concentrated in a limited
8 number of states that have mandated this, obviously. And
9 that will continue to grow based on what we're seeing.

10 Last area, a couple slides in terms of challenges,
11 to promoting fee-for-service alternatives for rural Medicare
12 beneficiaries. First, the whole notion of inadequate
13 provider networks, and that relates to the difficulty of
14 contracting rural providers. Basically, it's not going to
15 be easy to get providers to compete with themselves. If
16 they're the only game in town or there isn't much else in
17 town in terms of other health care opportunities, it's going
18 to be difficult to get them to basically sign on in terms of
19 provider network. That's a big issue.

20 Secondly, limited enrollment levels. It's going
21 to be hard just to go out and serve this population if there
22 aren't a lot of Medicare beneficiaries out there. Some of

1 that's related to limited employer demand for retiree
2 coverage. You don't have a lot of large employers out
3 there, so there's not that emphasis from that perspective.

4 And as Keith and others have pointed out then, the
5 relationship of this Medicare risk enrollment to commercial
6 level enrollment is important. If this is viewed as an add-
7 on to that commercial product that already exists,
8 potentially maybe we'll see some changes out in rural areas
9 as the commercial side grows.

10 Low and volatile AAPCC rates. I was told, don't
11 ask for more money. That's not the issue. Find out
12 something else in terms of complaints. So I'm not going to
13 ask for more money, but clearly the AAPCC rates do have an
14 impact. They're not the only issue, but there is a level at
15 which someone will go out and serve rural Medicare
16 beneficiaries through risk plans. We're not at that level
17 right now in many areas.

18 The volatility of the rates is just as important.
19 Not knowing what you're going to get next year, as Keith
20 pointed out, is really important. It has much, much more of
21 an impact on the smaller organization, an entity serving
22 fewer beneficiaries than on a larger organization. So that

1 volatility is just as important, if not more important, than
2 the actual level of the AAPCC.

3 High fixed cost of marketing and administering
4 Medicare risk plans. It's very difficult to do this out in
5 rural areas if that's the only product you're offering.

6 Then I mentioned the Marshfield experience. In
7 Minnesota, also up north we had the same experience.
8 There's a real perception of HMOs about adverse selection in
9 rural markets and that has definitely dictated their belief
10 that they just don't want to go out there. It's not worth
11 the hassle.

12 Finish up with a couple of thoughts about
13 promoting choice of Medicare beneficiaries in rural areas.
14 My first question is, does it lead to increased access;
15 i.e., we promote choice so we get new physicians? Are we
16 recruiting new physicians to the area, or new physicians are
17 serving the population? Does it lead to better quality;
18 i.e., improved referrals? Does it lead to lower cost, out-
19 of-pocket expenditures for rural Medicare beneficiaries?

20 I suggest there is very little evidence that
21 there's any benefit for rural Medicare beneficiaries to join
22 up in risk plans. So we need to think through why are we

1 doing this? It's unrealistic to expect competition to yield
2 desired results in areas with limited provider supplier and
3 low reimbursement rates. Having competing health plans with
4 the same provider panel isn't going to yield a lot of
5 benefits.

6 Lastly, if we want to promote choices, raise the
7 payment floor. At some point you'll get players. More
8 realistically, perhaps let's have more aggressive
9 implementation of blended rates. That certainly would help
10 in terms of getting health plans out to rural areas. We
11 need to develop strategies for more predictable growth of
12 future rates so health plans that go out to rural areas
13 really will understand from year to year that there aren't
14 going to be tremendous changes in what they're going to be
15 receiving.

16 Finally, let's try to -- I'll throw out, consider
17 alternatives to risk plans. Medicaid program certainly has
18 promoted primary care case management. They've started
19 doing some sole source risk contracting in Kentucky and
20 California. We need to think about, if risk contracts
21 perhaps are not the answer for some rural areas, are there
22 other ways that we can help promote health care to Medicare

1 rural beneficiaries.

2 I'll stop at that point.

3 DR. WILENSKY: The last one I think -- I hope we
4 can get into some further discussion about the primary care
5 case management and the sole source risk contract, I think
6 are very interesting issues that at least we have not had
7 much discussion about as policy areas.

8 At this point let me open up to the commissioners.
9 Any questions you have on any of the information presented
10 by any of the three presenters or issues that you'd like to
11 see us raise.

12 DR. NEWHOUSE: First let me thank all three of
13 you for coming and putting this together. I certainly
14 learned from each of your presentations and I have some
15 questions for each of you. My question for Gary is actually
16 the more kind of technical question which is, you made the
17 case that the rural delivery system is self-contained. Do
18 you know how differently the numbers would look if you used
19 dollars and included the inpatient side as well for both
20 Part A and Part B, in Medicare-speak? That is, as I glanced
21 at what you did, it looked like it was all based on
22 outpatient visits.

1 DR. HART: It was based on outpatient visits. We
2 had Part A and we did look at that. We weren't
3 concentrating on the financial part of it, but where people
4 were going. The number of rural hospitalizations and days
5 and things would look very much, in terms of aggregate would
6 look very much like the ambulatory things I showed. But in
7 terms of dollars it would migrate to the urban places
8 because the big cost items are in the tertiary centers.
9 You're right that way, it would change that part of the
10 equation. But the ambulatory part is 30 percent of the
11 expense.

12 DR. NEWHOUSE: Right. Then for Keith, I thought
13 personally that the issue with rural hospitals, and perhaps
14 physicians and other providers was a scale issue, as you, I
15 think, tried to make the case that there are diseconomies of
16 scale at small levels.

17 That leads me though to a couple of questions.
18 One is, how do you deal with the issue of volume-outcome
19 relationships? To somebody who said, we get better results
20 in bigger centers, so why are we trying to keep all the
21 small places afloat, how would you answer that?

22 DR. MUELLER: Two ways. First I'd want to see the

1 evidence about volume-outcome relationship by condition.
2 Must of the literature is based on the conditions that are
3 treated in tertiary centers, and I would have no
4 disagreement there. As Gary just said, they go there
5 anyway.

6 The second is, if you have the ambulatory visits
7 in mind or short term hospital stays, you need to have those
8 services available locally. These two reasons, two ends
9 just tie together, because I'm not convinced of the same
10 quality differential volume relationship when you get into
11 the short term services that primary care hospitals provide.

12 DR. HART: Just a comment about Hal Luft's work
13 and some others about the volume things. In fact, while
14 most of us gather that volume relationship is what we take
15 from his work, when you look at it closely for things like
16 appendectomies and cholecystectomies, there is no
17 relationship. Anything over about five it's flat. So
18 that's what rural hospitals do.

19 DR. NEWHOUSE: That's a fair comment. Then let me
20 come to the size-based payment because I've rolled that
21 issue around in my head, too. One way to look at that is,
22 in effect, Medicare would pay, or all payers would pay more

1 for small small entities because they cost more per unit.

2 One way to look at that is there's some additional costs to
3 Medicare. If Medicare doesn't pay them and these places go
4 out of business, there's no more travel costs or other
5 inconvenience costs for the rural population.

6 Has anyone, you or others, tried to look at the
7 magnitude of those costs? That is, if we went to -- if we
8 postulated, or based on evidence said, these are the costs.
9 This is how average cost change as you go down in size, and
10 therefore this is the size of the increased cost burden if
11 you went to size-based payment versus if you didn't and
12 these places weren't there, what would happen to travel
13 costs?

14 DR. MOSCOVICE: During the good old health care
15 reform days there was a little bit of work on that. Nobody
16 has really explicitly looked at pricing out the travel cost,
17 but they have looked at the notion that those folks are
18 going to get served in costlier institutions, and have
19 priced out the fact that if you closed some rural hospitals,
20 for instance, you're not really going to save money in the
21 system. In fact, you're going to raise -- they estimate
22 you'll raise system costs because the vast majority of those

1 people would get served in institutions that have a higher
2 cost basis. No one that I'm aware of really has priced --

3 DR. NEWHOUSE: Wait a minute, there's something
4 funny, because there are diseconomies of scale or there
5 aren't at the small end.

6 DR. HART: There's an intensity of what happens in
7 the two places -- very different. One of the thing we've
8 showed in a bunch of studies is in rural places they use
9 less resources per whatever they're doing.

10 One slide on what I showed was that when people
11 leave their local community, Medicare beneficiaries, they go
12 about 41 miles when they go to another rural place. They go
13 90 -- one way. Then they go -- in Washington, this is from
14 the data, we figured it, the road mileage. It's 92 miles
15 when they go to a tertiary center. That's 180, whatever 90
16 miles round trip. And then the time -- we have timing
17 thing. So it's possible -- you could start extrapolating.
18 But if they're aren't short trips --

19 DR. NEWHOUSE: Right. Then the last question for
20 Keith was just what I think is a minor point. You said
21 something about quantifying the impact on small rural
22 hospitals. The question just occurred to me, do you have

1 any data on how many of those might be a second hospital in
2 say a town of 40,000? Because the assumption I think was
3 that they were all basically the only -- it was a one-
4 hospital town, which seems reasonable for most of them. But
5 I just wondered if anybody looked at that.

6 DR. MUELLER: I don't have that precise number
7 with me, but part of the logic is that in the 1980s when we
8 saw a multiple problem with hospital closures or issue with
9 hospital closures -- let me rephrase that -- many of those
10 were the other hospital in a two-hospital community. So if
11 we went back now and looked at hospitals in communities we'd
12 find a much higher proportion of them as single hospitals.

13 DR. NEWHOUSE: Finally for Ira, both actually at
14 the beginning and the end of your talk you I think -- at
15 least I caught a tone of some skepticism about why one would
16 have a goal of increasing enrollment in Medicare+Choice in
17 rural areas, whether that goal makes any sense. But I also
18 -- and maybe the answer is, if you -- I'm with you, Ira, not
19 sure the goal makes sense. But if that's your goal anyway,
20 here's how you would go about it. Is that --

21 DR. MOSCOVICE: That's pretty much what the slide
22 says.

1 DR. KEMPER: I guess just to follow up on that.
2 You make the argument, which I also caught, that on
3 competitive grounds there probably isn't much to be gained
4 from having Medicare+Choice plans in rural areas. I guess
5 are there other ways in which they might improve care or
6 reduce costs, care management tools, ability to shift funds
7 among services, including some that aren't covered, managing
8 the tertiary care costs, the ones that aren't delivered in
9 the rural area? So I guess if you could comment on that,
10 the potential benefits beyond competitive aspects of having
11 a market.

12 The second question related is, there are areas
13 where there are risk plans. What do they do there? Do they
14 do anything different than the traditional fee-for-service?
15 What kinds of things do they bring in? Is there any
16 evidence on what happens there?

17 DR. MOSCOVICE: I think the first important point
18 to recognize is, it doesn't make sense to have risk plans in
19 some rural areas. That's just what you pointed out and I
20 tried to on the last bullet say that; for some rural areas
21 you might want to think about other things.

22 But when you look at where we have the highest

1 penetration, in Pennsylvania you have a Geisinger, you have
2 Keystone, the Oxnard Clinic is another. You have large --
3 you have delivery systems that have some size in them that
4 are located in rural areas that are providing services.
5 Clearly, they have the capacity to do this, no question
6 about that.

7 I just haven't seen -- I mean, the issue you
8 raised I think is an important issue: are there other
9 benefits? That's what I was trying to raise on the last
10 slide. I'm not aware of -- I can anecdotally suggest
11 perhaps things as you have, but I really haven't seen any
12 empirical evidence that suggests this. We're dancing around
13 this whole equity issue. And it's not just a rural issue.
14 Clearly, Minneapolis, we know about this issue a lot also.
15 If we want to be equitable then we can have -- you've had
16 this discussion with others. What does equity mean?

17 To say we're going to offer Medicare risk plans in
18 rural areas, and that's what we want. We want choices, but
19 those choices -- only 4 percent of rural Medicare
20 beneficiaries have access to drug plans out there as
21 compared to a much larger percentage in urban areas. If
22 their out-of-pocket expenditure is going to be higher, is

1 that equity? Is that how we're meeting our equity and
2 fairness issue? I don't think we are.

3 So I think we need to seriously consider, perhaps
4 there are some rural environments where there are other
5 kinds of managed care arrangements beyond this one which
6 makes sense. Primary care case management in the Medicaid
7 program has had some limited success. It's been there 15
8 years now. It's not the answer. It's not a lot in terms of
9 saving a lot of dollars, but it does seem to have benefits
10 in terms of coordinating care for the beneficiaries. If
11 that's important and that might lead to improved referrals,
12 great, maybe that's a model we want to use.

13 DR. NEWHOUSE: Is that evidence rural-based or
14 urban-based that you're talking about?

15 DR. WILENSKY: There's some of that -- the primary
16 care piece?

17 DR. NEWHOUSE: Yes.

18 DR. WILENSKY: There's some of that that's rural.

19 DR. MOSCOVICE: Some of it's rural, some of it's
20 urban. And sole source risk contracting is just something
21 that they've started with in the Medicaid program, and the
22 state of Kentucky has been pushing. Basically saying, let's

1 not try to get providers to compete against themselves, but
2 maybe they'll be willing to take on some risk-bearing
3 scenarios if they're going to be guaranteed that they are
4 going to be the provider of, the health plan of choice out
5 there.

6 You have to deal with the issue of provider choice
7 and what does that mean. Because when we say sole source,
8 we don't mean that in terms of providers, we mean that in
9 terms of health plans. It makes no sense to have health
10 plans competing against themselves with basically one
11 provider network; four or five doctors out there and asking
12 them somehow to make sense of this. It doesn't make sense,
13 so they've resisted tremendously.

14 In the places where we've seen networks develop, I
15 think the key is to get primary care providers and the
16 hospital in sync out in the rural areas. When we see them
17 starting to work together, those are the ones basically
18 where you have really in sync local hospital and a large
19 provider base -- it could be an IPA, it could be a large
20 group practice. But when they're together, then they're
21 willing to start take on some risk bearing associations.

22 But when I go out to rural areas, you know it's

1 all over before you start a site visit when you see the
2 hospital and the primary care provider has the same kinds of
3 technologies. They're competing with each other. It just
4 makes no sense. They're not talking to each other. So I
5 think we need to organize that local delivery system, and
6 that was the hope behind networks. It quite honestly hasn't
7 -- it's not happening as fast as we'd like, so there are a
8 variety of technical assistance programs that the Federal
9 Office of Rural Health Policy and other foundations are
10 trying to support to jump-start that process.

11 DR. WILENSKY: That was presumably the hope behind
12 the PSO, because that was exactly what it was designed to
13 do, although Wisconsin showed that you could do PSOs without
14 new legislation. I mean, they've been doing that for 30
15 years. But the fact was that -- that presumably was the
16 rationale -- and it's less clear, although after Bill and
17 Woody I have some questions to ask you about why you thought
18 that might not have --

19 DR. KEMPER: Can I just follow up with one
20 question? Have you thought at all about the risk selection
21 opportunities if you have a sole source contract and a
22 single HMO, a single provider basically?

1 DR. MOSCOVICE: There are going to be a whole host
2 of issues that we need to deal with. That's one of them. I
3 quite honestly have not thought a lot about how that's going
4 to play out. My friends Brian Dow and Roger Feldman are
5 trying to help with the implementation of competitive
6 bidding models. Now they have been mandated -- they've been
7 thrown out of community after community, but they've also
8 been mandated to try to get a rural site. And as hard as it
9 is to get an urban site, you can imagine what it's going to
10 be to get a rural site.

11 So there are a lot of issues though, you're right.
12 And there are other issues, but I just throw it out there on
13 the table. They haven't been worked out.

14 MR. MacBAIN: I think when we talk about rural
15 managed care we really have a tendency to use a model that
16 just doesn't fit at all. If you go back to one of the
17 ancestors of today's managed care, which is the prepaid
18 group practice, you find a much more relevant model of using
19 capitation as a way of providing a predictable revenue
20 stream to a small medical group in a rural area to secure
21 access. From that aspect it would make some sense. But
22 there you're looking at a way of developing a financing

1 mechanism for the local delivery system rather than a
2 benefit plan or some mechanism to improve efficiency.

3 When we get into areas such as rural providers
4 taking on the risk for services provided outside their own
5 walls or outside their own county it becomes extremely
6 risky, in the sense that they're literally betting the farm
7 on an insurance company when they don't have the reserves,
8 don't have the expertise. Provider-sponsored insurance
9 plans, PSOs have enough problems in urban areas because of
10 the expertise and the reserve issues, but it is really
11 compounded in rural areas.

12 I hope as we start looking at this more we can
13 focus, sort of back to the future on some of the origins of
14 the rural-based prepaid group practice plans and find out,
15 are there things in those kinds of plans that offer some
16 opportunities to capture more of the Medicare dollars that
17 are generated in rural communities and keep them there, keep
18 the local financing on a more predictable basis.

19 DR. WILENSKY: I'm a little confused about why you
20 couldn't set up a PSO as an old-fashioned prepaid group
21 practice.

22 MR. MacBAIN: You could. What I'm saying is you

1 wouldn't necessarily -- at least as I view it, you wouldn't
2 want a community of 5,000 people with a CHA and a handful of
3 docs taking on full risk like the PSO model for the Medicare
4 population when 70 percent or 80 percent of the
5 expenditures, including hospital expenditures are going to
6 be in places far away over which they have very little
7 control. One bad case, or a string of two or three, even
8 with reinsurance, could bring down the whole system. It
9 adds the business of insurance on top of the business of
10 providing health care in a way that gets you far away from
11 what you're really trying to do, which is secure a revenue
12 stream and improve the security of the local delivery
13 system.

14 But if you can carve out just the services that
15 are provided locally and say, we'll take risk for these and
16 use Joe's favorite mechanism of a split capitation, fee-for-
17 service system so that there's a per capita payment that
18 covers your fixed costs and then you get paid on a reduced
19 fee to cover your variable costs, then you've got a workable
20 mechanism. It's at least workable from the perspective of
21 the local delivery system and the local beneficiary.
22 Whether it's good for Medicare, I'm not quite so sure. It

1 probably is.

2 DR. MOSCOVICE: In fact, for the 40 percent of
3 networks that had physicians also, and for the 40 percent of
4 those that were taking on risk bearing -- so we're down to
5 about 20 networks or so. In fact, that's exactly how the
6 scenario played out. It was basically primary care doctors
7 that got paid on a partial capitation basis and then
8 specialists were fee-for-service, and that's exactly how it
9 did play out.

10 But just think about it from -- I agree with you,
11 and it's what we tried to say make sense. But think of it
12 from a five-person practice out there who's not done this
13 before. It means two things basically with the PSOs.
14 You've got to come up with X dollars to meet the solvency
15 requirement. Forget it. They don't have it. That's first
16 off.

17 They don't have it unless they get a partner. So
18 it means you have to get a partner. And it means maybe not
19 even the local hospital is the partner. It means you have
20 to partner with an insurer. This is something they're just
21 not used to doing. And it means you have to, as Bill just
22 said, build up that other component, the management of care

1 part that they're not used to doing. So it may happen, but
2 it's going to take time.

3 DR. HART: Let me just make one comment related to
4 that. Mostly we're talking -- they're different kind of
5 providers, but let me speak from the family physician part
6 of this. These rural providers in these small towns are
7 already working about 15 to 20 percent more hours than their
8 counterparts and make about the same amount of money. One
9 of the thing that's adding complexity to what they're doing
10 and one of -- there's a whole series of federal programs
11 aimed at trying to get rid of shortages in these places. So
12 these are not places where there's -- you know, it's not a
13 buyer's market.

14 And the other thing is, all this adds to the
15 overhead. One of the things I've been thinking about lately
16 is the minimum size of the places. I've been out doing a
17 bunch of site visits and looking at some of the numbers it
18 seems like -- the solo practitioners are disappearing. The
19 rural ones are in trouble. And the more rules there are per
20 patient one sees, or the more complex all this gets, the
21 bigger the minimum size place gets. Remember, there are
22 towns that aren't even big enough for one physician. So one

1 of the things we're having here is the access in a lot of
2 real small places is liable to go away as we make more and
3 more complexity.

4 MR. MacBAIN: Which again gets back to that logic
5 that some of the old prepaid group practices, in places
6 where you had nothing, if you were going to have something
7 there you had to be able to guarantee an income. Then to do
8 that, if you got an enrolled population and capitation --

9 DR. HART: Which is sort of the model.

10 MR. MacBAIN: But it's a whole different objective
11 from what we talk about usually when we talk about
12 Medicare+Choice.

13 DR. HART: I was doing a site visit in Wales a
14 year ago with John Wynn Jones there who's -- you know, it's
15 a small town. They got three docs. It's isolated. And
16 they have a steady income. They get an exact amount and
17 then they plan the care for the community.

18 DR. MYERS: First of all, I enjoyed your
19 presentations very much. I learned a lot. As a former
20 commissioner of a state health department not dissimilar
21 from Minnesota, Wisconsin, and Washington, we had the urban
22 and rural issues in pretty much equal proportion. I'd like

1 to tell you some of my biases and perhaps you've got some
2 data to convince me that they're not true.

3 My walking-around knowledge of the rural hospital
4 is that the intensity of services, as someone alluded to,
5 was lower. The severity of the average patient is lower.
6 The through-put is certainly not as crisp, not as efficient
7 as it is in the urban setting. The style of practice is
8 different. These are issues that tend to make the average
9 rural hospital patient looks a lot different than the
10 average urban hospital patient.

11 You talk to a resident that trains in Los Angeles
12 and moonlights in San Joaquin Valley, they'll tell you that
13 the congestive heart failure patient admitted in one place
14 is very different than that admitted in another. You talk
15 to the resident in Indianapolis who then goes out into
16 private practice near Huntington, Indiana you'll find that
17 they will admit very different people to the hospital out in
18 the rural areas than they will admit in the urban areas.

19 So you combine this with the pride that smaller
20 communities have in having a hospital. In fact, in my
21 experience that pride is not at all dissimilar from larger
22 cities and professional sports stadiums. If you don't have

1 a pro football team or a basketball team, you're not on the
2 map as a big city. Whereas, the smaller towns feel if you
3 don't have a hospital with inpatient capacity, you're not on
4 the map as a viable community.

5 So the fact might be then that we have a number of
6 places that have inpatient capacity that is under-utilized
7 or inappropriately utilized when in fact those fixed costs
8 could be better spent in revitalizing home health or other
9 outpatient services. As the model of care changes, as we're
10 able to do much more on an outpatient basis, instead of
11 taking pride in that and declaring success, and therefore
12 decreasing or eliminating inpatient capacity, we tend to
13 hold onto inpatient capacity instead.

14 One of the experts is to my right and I'd like to
15 hear his comments as well. But what about that scenario
16 don't you believe, or where is there data that contradicts
17 that?

18 DR. MUELLER: You raise a couple of points. One
19 is that hospitals in rural areas have indeed, since
20 especially the advent of prospective payment in the '80s,
21 been doing a lot of what you're talking about, trying to
22 diversify their services, reinvest and invest their capital

1 differently. They've not always reduced the size of the
2 physical plant of inpatient beds. They have reduced numbers
3 of licensed beds in many of the hospitals, converted them to
4 long term care beds or swing beds. So that has indeed been
5 one of the responses in a lot of rural areas.

6 Another response to a lot of what you say is
7 creating in our payment policy as Medicare is doing now,
8 different options, because it will vary. I've looked at
9 outpatient and inpatient data for Nebraska hospitals and the
10 rural hospitals are providing many of the same types of
11 services that you'd expect for a 35-bed hospital that you
12 could get in an urban area, and I'm not seeing differences
13 in length of stay or in quality, and I'm not hearing that
14 from patient satisfaction surveys.

15 On the other hand, some of them are very small
16 that really ought to downsize into something other than the
17 full-service acute. Having the critical access hospital
18 program now provides that option to the rural hospitals.

19 So I think you raise the right issues, and they've
20 been the same issues that have been coming up. One of the
21 challenges will be working with the local communities that
22 undergo a change in name of the local institution from such

1 and such medical center to such and such access hospital, if
2 they call it that, or changing -- so the community
3 understands the care level hasn't changed, just some of the
4 way the payment streams work out and the way the hospitals
5 are organized.

6 DR. HART: That there are some hospitals that may
7 be superfluous in the sense that you're talking is probably
8 true. But one of the problems is in the spiral of
9 eliminating hospitals, there's usually -- the economics and
10 things that we're talking about in the programs, the
11 dropping of hospitals as in like when 250 closed in the late
12 '80s, some of those were in towns where there was two or
13 where towns were close together.

14 But we did a study where half of them were more
15 than 30 or 40 miles from another place, so it's sort of
16 indiscriminate. If you put the screws on and tighten up and
17 have places close, the ones that are 50 miles from anywhere,
18 or 60 or 70 miles, are almost as likely to close as the ones
19 that are four miles from a place.

20 So if you come up with some way of differentiating
21 or being more selective, but as things stand now we're just
22 making things tight. And out in Washington we're hard-

1 pressed, or Alaska, or Montana, or any of those states, to
2 look out there in the rural areas and find many hospitals
3 you'd feel good about pulling out even though they're not
4 doing the high level sorts of things, because they're the
5 only thing in 70, 80, 90, 100 miles.

6 DR. WILENSKY: One of the difficult questions that
7 I thought was faced by Medicare when I was at HCFA is that
8 in some of the cases the problem was that these were
9 hospitals that were very small with 25 percent occupancy,
10 and it was hard to imagine a payment that was going to solve
11 that problem.

12 DR. MOSCOVICE: Those facilities --

13 DR. WILENSKY: I agree that it's -- there's
14 certainly a more difficult issue when you have significant
15 difference but there is -- at least it seems to me that we
16 have some examples where there really was no imaginable
17 payment the Medicare would make that was going to sustain
18 the hospital because it was so small, with such a low
19 occupancy, all of it Medicare.

20 DR. HART: And a great number of those communities
21 are -- communities subsidize those hospitals. So there's
22 got to be some balance. It's got to be worth it to the

1 community. But one can't make it out of their reach.

2 DR. MOSCOVICE: But the goal of the public policy
3 shouldn't be to keep rural hospitals open, and very often
4 state legislators particularly -- you go in there and you
5 say, network development has got nothing to do with keeping
6 rural hospitals open and they'll show you out of the room.
7 It just happened to me. But it shouldn't be to keep the
8 hospitals open. Those hospitals should become rural health
9 centers. They should be doing a limited amount of inpatient
10 care. They should convert to critical access hospital
11 status. They're crazy if they don't, particularly if we
12 move to a four-day average.

13 So those facilities really aren't inpatient
14 facilities, the small ones. There are larger facilities, a
15 quarter of the hospitals are above 100 beds. There are a
16 lot of facilities that really are rural referral centers,
17 and they look like urban. But the bulk that are really
18 small, they really should become rural health centers if
19 they want to survive over the coming decade because they're
20 not going to be able to survive. There's nothing you can
21 do, as you're saying, on the inpatient side to make life
22 easy for them.

1 DR. MYERS: Should we help them evolve in some
2 way?

3 DR. MOSCOVICE: Absolutely. And the Federal
4 Office of Rural Health Policy and others are really trying
5 to do that.

6 DR. MUELLER: That is what the critical program
7 is. I would agree that you can't expect to keep the
8 hospital open with the payment stream, but you need to look
9 for options so that the Medicare payment stream in
10 particular, because it is such a big percentage, doesn't
11 exacerbate the situation. So that it can't be pointed to as
12 the causal factor. I think it's right, they have to have
13 the local subsidy. I've been in a few hospitals recently
14 that I wish would close as well.

15 DR. HART: Just as a counterpoint to that is --
16 actually, it goes along with it. If we cut things so close
17 to the margin, what invariably happens to these small places
18 -- remember how I talked about being fragile. If you've got
19 three docs in town, an administrator really, and the
20 economy, say it's farm. You get a farm crisis, a doc
21 retires, or two docs retire, and you get an administrator
22 who isn't top flight. Any one of those three things, or any

1 combination of those will bring a place down, if the
2 finances are so close. They all have to be there.

3 So there needs to be some -- I don't like to talk
4 about -- but there needs to be a margin that allows for some
5 error because they aren't always going to have all three
6 docs, they aren't always going to have a top flight
7 administrator. And it's irrespective of the need of the
8 community.

9 MR. JOHNSON: Just a couple comments on this.
10 Number one, we're looking at this as health policy wonks and
11 intelligentsia, but there's a lot of emotion with a
12 community hospital in a rural community. In Michigan, a lot
13 of the small hospitals are existing next to the 60-bed SNF
14 unit, so there's that support.

15 You don't recruit a doctor to a rural community
16 unless you have something like a hospital where there's some
17 capital investment in x-rays, lab, something else. You
18 don't recruit or maintain a lot of business if you don't
19 have some sort of a hospital or access to a referral type,
20 critical access hospital into the regional medical center
21 that might be 100 miles away.

22 So I don't think it's all a matter of health

1 policy and just finding the right formula and the right
2 reimbursement system. This is a very emotional issue to a
3 lot of local communities.

4 DR. WILENSKY: But I think actually, in fact, it
5 was trying to look at the economics that came up with the
6 essential access and critical access ideas that led to the
7 critical access program to allow for the fact that there was
8 some needed services, but in fact it wasn't going to be
9 economic on the basis that --

10 MR. MacBAIN: The other piece of that is the
11 economic role of the small hospital in a small county. That
12 even a small hospital may be among the top three employers
13 in the county, may be a major economic generator. So it's
14 not just an emotional attachment, it's a major economic
15 issue and is a social focal point for organizing health
16 care.

17 DR. LAVE: I want to concur that this was really
18 extraordinarily interesting and helpful. But I'd like to
19 push each of you to -- there's a question I want to raise
20 and then I want to ask you to address something. One
21 question we've not talked about here in the context of rural
22 health care has been the whole issue of telemedicine. There

1 has been some expectation that maybe telemedicine may play a
2 role also with respect to keeping physicians there because
3 they have a different kind of access to rural communities.

4 So I guess that I wondered whether or not you'd
5 thought that the Medicare program and MedPAC ought to be
6 thinking about telemedicine in any way that might be
7 different that you might help us with.

8 I guess the final question is that, if you were to
9 give us one word of advice about how to think about rural
10 questions that would be helpful for us in the future, what
11 would it be?

12 So could you address the telemedicine?

13 DR. HART: Telemedicine, we're doing a bunch of
14 evaluations of telemedicine programs and it's sort of a
15 technological imperative. I mean, it's going to have to --
16 there's always been a part of me that says we're going to
17 have it no matter any way so...

18 But certainly there's potential through paying for
19 telemedicine to do a lot of things. From the standpoint of
20 the WWAMI program, from education standpoint --

21 DR. LAVE: What's WWAMI?

22 DR. HART: Washington, Wyoming, Alaska, Montana,

1 and Idaho. It's a regionalized medical program, one medical
2 school in five states. From that standpoint, we're in about
3 30 percent of all the sites in all of the rural areas so it
4 makes sense that way. To cut down the isolation of the
5 rural providers who are out there, it's a real plus. It
6 saves -- I think it potentially can save a lot of money for
7 rural folks who need to see specialists. That is, they
8 won't have to travel, and especially the elderly and
9 Medicare folks because of the inconvenience of driving three
10 -- you know, it's an eight-hour trip kind of thing. A lot
11 there.

12 But there's another side to it all. There's a
13 tendency to think of it as a cure-all; something that's
14 going to fix something. Remember, these are rural places
15 that have shortages of providers to begin with. If I'm a
16 family physician in a rural place and you give me -- I've
17 got all this telehealth stuff there, and I'm seeing 140
18 patients a week and I'm overworked to begin with, the
19 easiest, fastest thing for me to do is write a referral and
20 forget it.

21 So it's not going to solve the problems of the
22 time of the rural providers out there in those place. The

1 savings will be to various folks, but not likely to be a lot
2 to those providers, and that's where one of the big problems
3 is with the shortage of that. So I think it would help some
4 things but not others.

5 DR. MUELLER: I would expand on that just a little
6 bit to say, think in terms of telecommunications.
7 Telehealth often times brings with it this picture of
8 getting actually health care delivered, and that is an
9 important piece. But if you're talking about keeping rural
10 providers active and satisfied in their jobs,
11 telecommunications more broadly defined is, I think, perhaps
12 even more important, so they have the linkages to the
13 colleagues that they want.

14 The one word of advice would be to reiterate what
15 I said earlier, that any time we think in terms of payment
16 changes or policy changes, one of the categories we think of
17 is the small, isolated provider and what effect do we have
18 on that provider in making this policy change.

19 DR. MOSCOVICE: With respect to telehealth,
20 telecommunications, I think Mr. Gates within a decade is
21 going to have all of us using our TV for just about
22 everything. I think at that point, once it's part of our

1 lives, then I think it's going to have a real impact
2 potentially. But until then, I think it's good to have
3 these demonstrations, but that's what they're going to be.
4 Most people are not going to have access to telehealth.

5 Up in Alaska they've been using it for many years,
6 and in isolated environments, as Gary was saying, it can be
7 helpful. But until we move to the next state of technology,
8 which I think we will within a decade, and it becomes
9 ingrained as part of the way we deal with things, and
10 hopefully reimbursement will come along the way also in
11 terms of paying people for being involved with those
12 communications, I think it's an add-on, it's not going to be
13 central to solving problems.

14 If you want the bottom line from my perspective
15 is, don't try to force urban-based solutions into rural
16 environments. They may work in some, but they're not going
17 to work in all. You're not going to solve the cost problems
18 of Medicare or any other program out in rural America.

19 The issues you should be dealing with are access
20 and quality of the services. Make sure Medicare
21 beneficiaries really do have some access to services. It
22 may be through risk plans, it may be through other options.

1 And to make sure that we start developing
2 information systems and others so this mythology that bigger
3 is better, that you can only get quality health care out
4 there in university-based academic health science centers --
5 if we have empirical literature, great. But we don't for
6 most of the particular diagnoses that we want to look at.
7 There's no evidence that pneumonia gets treated better in an
8 urban environment than a rural environment.

9 There's an excellent article that Bob Schlenker
10 did on volume-outcome and what relationship it has to rural,
11 and it backs up what Gary said, which is there are certainly
12 some diagnoses it's clear you need a threshold. But the
13 majority of diagnoses you don't. It goes either way, quite
14 frankly, at this point.

15 DR. HART: I guess for my word I didn't put that
16 part -- diversity, I guess. You shouldn't have -- when I
17 say rural, you shouldn't have a picture, because there is no
18 picture. It's a lot of things in a lot of places and it
19 depends on what you mean. To many, too often we make a
20 policy for rural which is places of 300 to places of 40,000.
21 It doesn't make any sense.

22 MS. NEWPORT: Gentlemen, thank you very much.

1 Very interesting. I just last week had a rather interesting
2 debate within our organization about, we are all things, as
3 the largest Medicare HMO in the country, to all areas, and
4 I've been arguing for about eight years that we shouldn't be
5 representing ourselves as that. So you've just confirmed
6 how right I am about this.

7 But a couple comments I think were very important
8 and just to reemphasize is that big state, urban state
9 capitals, and big urban-based HMOs really aren't the
10 solution. We're going to have to slice this very
11 differently in order to try to serve these populations.
12 I've been just very intrigued by some of the ideas here in
13 terms of going back both to my organization and to the
14 industry and say, we have to be a lot more ingenious about
15 how we represent as solutions for everyone and choice when
16 that may not be the answer to the problems and the
17 challenges you're facing.

18 So I thought it was a very interesting discussion.
19 Thank you.

20 MR. JOHNSON: Just in terms of unintended results.
21 The most significant use of telemedicine in northern
22 Michigan, above the bridge as they say, is for prisoners.

1 The correction system has found that it's easier to use
2 telemedicine with the UofM or Henry Ford Hospital than to
3 get two guards in a vehicle and spend five days getting
4 treatment for the prisoner.

5 DR. HART: Virginia and Texas and a bunch of other
6 states are doing that, too.

7 DR. LEWERS: Along the same lines with
8 telemedicine, of course, the Navy has extensive experience
9 with that. But the point you make about you've got to have
10 personnel there to help. And when we start talking about
11 the advances I think we talked about here, that even with
12 some of the robot stuff that's coming -- and it's here.
13 It's not coming, it's here. You can do surgical, and very
14 complicated surgical procedures as long as you've got a pair
15 of hands on the other end.

16 But a lot of the people that have made that, East
17 Carolina and some of their programs and some of the others,
18 have used physician extenders. What in your research --
19 where is that role, the role for the physician extender to
20 expand that sort of service component, where do you see that
21 going?

22 DR. HART: We've been doing a series of studies

1 about physician assistants and nurse practitioners and
2 others. In fact, there's a couple of things in process now.
3 We found in Washington that nurse practitioners and
4 physician assistants, generalist nurse practitioners and
5 generalist physician assistants provide about 30 percent of
6 all the generalist primary care that goes on in rural parts
7 of Washington. So it's a significant, important part of
8 that. They overlap with family physicians and general
9 internists and general pediatrics in some areas, and not in
10 some areas. So there's a portion that needs to have a
11 physician accessible someplace. But it's an important role.

12 There's some things to keep in mind. They aren't
13 much more likely to go to rural places than are physicians.
14 They are specializing too in the same ways that we have been
15 upset with physicians specializing. That is for -- we just
16 did a national survey of physician assistants and 53 percent
17 of them are what you'd call specialists. I mean, 18 percent
18 of them were surgical assistants.

19 But that doesn't take away from those who are
20 generalists who are doing a good job, and they have the
21 ability because of the financial side of things and what it
22 takes to break even and things, to go into some littler

1 communities then. And also take care of those fractions, if
2 you need 1.5 providers in a town. I mean, there are all
3 these kind of situations. Or you need somebody half --
4 there are lots of circumstances where they really fill the
5 bill.

6 And physicians in training, and nurse
7 practitioners and PAs are learning to work better from
8 school now, unlike the ones that are out there that had to
9 kind of learn it --

10 So there's a lot of progressing. It's still
11 relatively small numbers in rural places if you -- I'd have
12 to think of the exact numbers. But I mean, it's 30,000 PAs
13 and 30,000 nurse practitioners. But as Buzz Cooper has
14 shown recently, if you look at the curves for the mid levels
15 it goes up in almost an exponential kind of move for nurse
16 practitioners. So there's going to be a lot more, and one
17 of the issues is how many of them are going to go to rural
18 areas, and I don't know the answer to that.

19 DR. LEWERS: That was my second question, how many
20 are going out there?

21 DR. WILENSKY: I had a question or suggestion for
22 Keith and a question for Ira. Keith, you mentioned the data

1 issue and cited the Ernst & Young study or the Lewin study.
2 As I think you know because of the conversations you and I
3 have had, our concern has been that these studies are
4 basically projections off of a '97 base. It's not to say
5 that they're wrong projections, but that they don't replace
6 data on where we are now.

7 As you've indicated, it's particularly ironic that
8 most of their conclusions assumed things that haven't yet
9 started, like the outpatient PPS, and that probably aren't
10 going to be there to give the kind of answers. I was just
11 looking quickly at the Louisiana and the North Dakota, one
12 of which is a survey as opposed to cost reports and the
13 other which is based on three hospitals.

14 Anything that you or any of your can do to try to
15 help get us real cost data quicker on what's going on in
16 rural areas would be enormously helpful. We are already
17 struggling with when exactly are we going to get the 1998
18 hospital data, and here we are about to go into 2000. So
19 any kind of activities that if you ever hear being raised
20 about trying to actually get some data, particularly data at
21 a cost report type level, from rural areas that could come
22 in an expedited way would help us enormously.

1 MedPAC, working with HCFA, has been trying to do
2 this snapshot, rush data collection. We'll talk some more
3 about where that's going to keep us in terms of giving a
4 little bit of an advance '98 and maybe early '99 data. But
5 it really has been a problem.

6 It's not that we're adverse to projections, but
7 projections aren't an actual look at where we are. So
8 anything that is ever in your power in your roles in rural
9 health care to do, I think we would find it enormously
10 helpful. I think we've all been very frustrated that we're
11 at the end of '99 and we can't even see the effects
12 empirically of what was done. So again, any areas that you
13 could help on that I think we'd be really grateful.

14 Ira, you mentioned or commented on the adverse
15 selection issue reported by Marshfield. We asked a few
16 health plans to come in and talk to Murray and myself and
17 some of the MedPAC staff about why they were able to provide
18 some of the opportunities in FEHB or in commercial plans but
19 seemed to have so much difficulty when it came to Medicare.
20 Sometimes it was because of the inability to use a blended
21 rate which actually reflected a higher cost for rural rather
22 than a lower cost.

1 But there was another comment that was made, and I
2 don't know whether you think this is what was going on in
3 Marshfield or whether you know about it. That is that the
4 people who were going into the Medicare HMOs in rural areas
5 were typically Medicare only.

6 So the problem that they were having is that they
7 were being paid comparable to traditional Medicare, which
8 has deductibles and coinsurance payments. These were now
9 people who got into the network where they no longer had to
10 face deductibles and coinsurance and may well have had some
11 pent-up demand since they were typically people who didn't
12 have wraparound insurance policies, and had access to
13 whatever there was available. Maybe they were the same
14 physicians or maybe it was slightly better. So they were
15 using a lot of services. But the payment was based on
16 traditional Medicare, which tends to be lower in general.

17 It wasn't really adverse selection of what we
18 think about as being the sicker population particularly as
19 just you artificially changed the rules that these people
20 were facing and what you were getting paid on assumed a
21 different kind of base. So I don't know whether you think
22 that has --

1 DR. MOSCOVICE: That happened up in northern
2 Minnesota with Blue Cross-Blue Shield, that exact scenario
3 where basically it was pent-up demand from people who didn't
4 have coverage before. But I think the thing is -- I shared
5 an article that Michelle Casey had published in the HCFA
6 Review, and she went out to some of the largest players and
7 non-players in rural areas to find out folks who were
8 offering plans and not offering plans, and talked to the
9 directors or the marketing people in these plans to try to
10 understand. And the selection issue and pent-up demand came
11 up sometimes. It's not in any way, shape, or form uniformly
12 across these plans.

13 What does seem to be the case -- and Greg Nitch
14 probably is the best person to talk to about the Marshfield
15 experience -- it takes a long while to get over a bad
16 experience and that permeates the state. I'm not sure
17 across state boundaries, but it really did hurt what was
18 happened in Wisconsin substantially. So pent-up demand I
19 know did occur in Minnesota and we haven't really been back
20 out there since.

21 MR. MacBAIN: Actually Marshfield is a good
22 example of what can go wrong with the best of intentions and

1 the best of design with a provider-sponsored plan. I think
2 Geisinger was exposed to somewhat similar -- I'm not sure if
3 they ever did any real analysis.

4 But if in fact people who are seriously ill or who
5 are anxious about being seriously ill will hesitate to join
6 a health plan if they think it's going to bar them from
7 their preferred source of secondary and tertiary care, then
8 when that health plan is sponsored by the premier provider
9 of secondary and tertiary care such as Marshfield or
10 Geisinger in a rural community, a significant bar is
11 removed. So you're going to get, if not adverse selection,
12 at least -- you're going to be seeing all the patients you
13 were seeing before.

14 And in a medical group or a provider-sponsored
15 health plan it's most likely that you're going to get the
16 same patients, and you're going to treat them in the way,
17 you're just going to get paid a little less for them. I
18 think that's what -- at Marshfield.

19 Whether that's unique to large, mulitspecialty
20 groups that sponsor their own HMOs or whether it's something
21 that everybody ought to worry about in rural areas, I don't
22 know. I'm not sure that --

1 DR. MUELLER: The same phenomena was reported out
2 of the Yellowstone plan in Billings, Montana, experienced
3 the same kind of spike in utilization. And I'd quickly add,
4 there is a policy option as part of the BBA refinement are
5 looking at. I'm not sure it's the right one because I
6 haven't seen the analysis, and that's a bonus payment to a
7 plan that goes into a county for the first time. That lasts
8 a year or two to help cover that initial spike of
9 utilization.

10 DR. WAKEFIELD: What, about 5 percent?

11 DR. MUELLER: Yes. I'm just not sure that's
12 enough, frankly.

13 DR. WAKEFIELD: I think in the proposed
14 legislation it's about 5 percent. The question is, is that
15 adequate?

16 DR. LEWERS: It didn't work for physicians so they
17 haven't learned anything yet.

18 DR. HART: We did a study a while back looking at
19 Group Health Cooperative Puget Sound as they were taking
20 contracts for Medicaid folks, and their experience was that
21 there was a spike for six months and then as they sort of
22 socialized the folks and caught up on the demand, I think

1 it's leveled off and they claim, at least through the data
2 it looked like they -- just looked like the other members of
3 Group Health after the six months.

4 DR. NEWHOUSE: Going back two decades, that was
5 also true for Group Health in King County, the new enrollees
6 had higher utilization for about six months as I recall.

7 DR. WILENSKY: Hugh, did you want to ask our
8 closing question?

9 DR. LONG: Thanks, Gail. My thanks also to all of
10 you for the presentation. It was very useful. It's
11 expanded my thinking in a number of dimensions and confirmed
12 a few things, and what I've been hearing is that we have
13 institutions that are fairly fragile, not very many fiscal
14 degrees of freedom if things go wrong, diseconomies of
15 scale, fairly high fixed costs. That rural is not rural is
16 not rural; it's very, very diverse. That we have to keep in
17 mind the small part of the small. That we shouldn't think
18 urban in terms of solutions.

19 That raises in my mind then the following question
20 as to what each of you might think is the appropriate role,
21 if any, for the rural sectors in education of clinicians and
22 practitioners, whether we're talking about primary care

1 residencies, the training of nurse practitioners, or the
2 training of other physician extenders? Should we be even
3 thinking about educational activities in this very fragile,
4 diverse, urban-isn't-what-it-is, setting?

5 DR. HART: There's always a part of me that wants
6 to turn that around and say, what if I said, what if we were
7 training all the physicians and PAs and nurse practitioners
8 in the country in rural places and I claimed there was no
9 need to train anybody for inner-city care? You would choke
10 on that. So the response is that it isn't the same.

11 And because it's not the same we need -- let's say
12 there was no big advantage, and let's say you didn't even
13 get more -- make it so that there was more rural providers,
14 which I think it does. Let's say it didn't do any of those
15 things. Let's say all it did was train the physicians and
16 nurse practitioners and PAs to be better doctors in rural
17 circumstances. That would be good enough I think.

18 It's a very -- ask folks that have been -- about
19 going out and practicing out there. They do have to have --
20 they do see a broader spectrum of things. It's true that
21 rural hospitals have, their case mix level isn't as high as
22 urban places. But when somebody comes in the door with an

1 MI, it's an MI. So there are -- and there's no backup.

2 It's a very different situation. You have to be able to do
3 different things.

4 Because you're talking to -- a real bias -- you
5 know, the WWAMI program is built around the idea of keeping
6 people out there and training them for rural practice in
7 those places. So I'm a very big advocate of that and I
8 think it gets more folks out there because it exposes them
9 to it, or at least doesn't let them come back to the city.
10 It trains them to be better physicians there, socializes
11 them the right way, adds support. The docs out there love
12 it. It's one of the ways we keep them from feeling remote
13 is to put physicians out with --

14 There's more, but I think there's a whole series
15 of reasons why it's important to train them. The same as it
16 is important to train folks for inner-city kind of practice
17 and emergency rooms.

18 DR. WILENSKY: Thank you. I'm going to ask if
19 you'll just remain there, I'm going to have public comment
20 now and then we'll close our session. If anyone who'd like
21 to make any comments, not just limited to the rural session,
22 any of the other areas that we discussed this afternoon,

1 this is an appropriate time.

2 Okay, thank you. We will convene tomorrow at 9:00
3 in the morning. Thank you very much, all three, for this
4 very interesting session on rural care.

5 [Whereupon, at 4:39 p.m., the meeting was
6 recessed, to reconvene at 9:00 a.m., Friday, November 19,
7 1999.]

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